CHAPTER 1

ACUTE CARD WARDS

STANDARD OPERATING PROCEDURE

500 BED FLEET HOSPITAL

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500 BED FLEET HOSPITAL

STANDARD OPERATING PROCEDURES

ACUTE CARD WARDS

A. **MISSION**: To provide medical/surgical nursing care to patients who have sustained injury in the combat environment. For the purpose of a "Humanitarian Mission" pediatric dose medication will not be stocked in the hospital. Doses will be prepared from in stock drugs (1) by Pharmacy when practical; (2) in all other instances, nurses will be responsible for calculating, preparing, and providing the most convenient method of medication administration.

B. **FUNCTIONS**:

1. Provide full-range of basic nursing care and treatment

2. Support general well-being of patients (psycho,social, spiritual, physiological needs).

3. Provide nursing care during emergencies.

C. **PHYSICAL DESCRIPTION**:

1. Acute Care Ward.

(a) Location within complex:

(b) Sheltering.

Type: Temper Tent.

Quantity: One to fourteen, 11 section wings.

(c) Material.

IOL: A10B-E, A11B-E, A12B-E, A13B-E, A14B-E, AX1B-E, AX1P, AX2B-E, AX3B-E, AX4B-E, AX5B-E, AX6B-E, AX6B-E, AX7B-E, AX8B-E, AX9B-E.

2. Clinical Work Space.

(a) Location within complex:

(b) Sheltering.

Type:	Expandable, Hardwall Shelter.
Quantity:	One 1:1 ISO Shelter.

(c) Material:

IOL:	A10B-E, A11B-E, A12B-E, A13B-E, A14B-E, AX1B-E, AX1P, AX2B-E, AX3B-E, AX4B-E, AX5B-E, AX6B-E, AX6B-E, AX7B-E, AX8B-E, AX9B-E.

D. **SPECIAL CONSIDERATIONS**:

1. Each ward is self-sufficient and the same in design and equipment.

Each unit is equipped with emergency equipment to support cardio-pulmonary resuscitation: (anesthesia endotracheal sets, SPARK's kits, defibrillator life pack, hand-powered resuscitator, portable ventilator, oxygen, and suction.)

2. The more critical patients should be placed closest to the nursing station on each ward.

3. Ward One will be used as a step down unit from the intensive care unit. The more critical patients will be admitted.

4. Ward Fourteen will have 15 beds reserved for neuro-psychiatric admissions. A psychiatric nurse and N-P techs will staff these beds.

5. Ward Five will be used as a holding area for expectant patients admitted to Casualty Receiving Area. A curtain will partition these patients from other ward patients.

6. There is no ward specifically designated for isolation.
Generally, sections of wards away from central area can be partitioned off to promote isolation. If the census shows a large number of isolation cases, the Commanding Officer may

specifically designate an isolation ward.

E. **WORKLOAD**:

1. There are 14 wards each with 30 beds = total of 420 bed capacity.

2. Average daily admissions.

(a) Steady state - 80 admissions/day to hospital, 56 admissions to wards.

(b) Peak state - 120 admissions/day to hospital, 84 admissions to wards.

Note: In steady state, 70 percent of all hospital admissions (n=56) are to the wards. However, 60 percent of the patients (n=34) are admitted indirectly after going to the operating room and ICU/recovery room. The remaining 40 percent of the patients (n=22) are admitted directly from Casualty Receiving area.

3. Ratio of medical to surgical patients.

(a) 2/3 patients are surgical cases.

(b) 1/3 patients are medical cases.

4. Average length of stay = 4 days.

F. **ORGANIZATION**:

1. Responsibility. The Ward Medical Officer, who is responsible for the medical care of patients, reports to the Head, In-Patient Medicine. The Charge Nurse, who is responsible for the day-to-day operations in the area, reports to the Patient Care Coordinator and the Ward Medical Officer.

2. Organization chart.

Head, In-Patient Medicine

Ward Medical Officer

Patient Care Coordinator

Charge Nurse

Staff Nurses Senior Corpsman

Staff Corpsman

----------Direct Relationship
- - - - - - - Indirect Relationship

3. Staffing.

(a) **Criteria**.

(1) Ratios of staff per 30 bed unit/per watch.

Medical Officer *.5

a A.M. Watch Nurse 2 Corpsman 4

Medical Officer *.5

b P.M. Watch Nurse 2 Corpsman 3

Medical Officer on-call covers two wards.

(2) Assignment of personnel on each watch can be redesignated by the Patient Care Coordinator depending upon ward census and nursing care requirements.

(b) Staffing pattern: Two 12-hour watches.

	Ward A.M. Watch	Total A.M. Watch	Ward P.M. Watch	Total P.M. Watch	Total Assigned
Medical Officer	*.5	7	.5	7	14
Nurse Corps	2	28	2	28	56
Corpsman	4	56	4	56	112

4. Personnel Assigned by Billet Number: See TAB A, page 13.

5. Watch Bill: See TAB B, page 28.

6. Special Watches: N/A.

G. **TASKS**:

TASK	METHOD
1. ADMIT PATIENT TO WARD	1. Upon receiving word of admission from Casualty Area
Receiving or ICU / Recovery Ward, prepare field bed to admit patient.	
	1.1. Assign patient to field bed.
	1.1.A Explain mechanical functions of bed.
	1.1.B Caution about getting out of bed because of height from deck.
	1.1.C Explain use of abdominal strap to prevent fall from narrow bed.
	1.2 Check patient's identification band.
	1.2.A Call patient by name.
	1.2.B Verify spelling of name.
	1.2.C Verify social security number.
	1.3 Obtain admitting /transfer vital signs. Record in TPR log.

1.4 Orient patient to physical surroundings.

1.4.A Location of heads.

1.4.B Location of shower.

1.4.C Laundry basket linen closet.

1.4.D Issue pajamas, robe, wash cloth, towel, and slippers.

1.5 Explain daily ward routine.

1.5.A Ward procedure for meals.

1.5.B Routine hours of meals.

1.5.C Types and availability of nourishments.

1.5.D Issue of bed linens.

1.5.E Time of WMO rounds.

1.5.F Mail.

1.5.G Explain to non-infectious ambulatory patients that they will be asked to help other patients with their activities of daily living and with ward

routines.

1.6 Obtain patient profile information and record on Patient Care Plan.

1.6.A Interview patient for information.

1.6.B Request patient complete information if alert and stable.

1.7 Notify Ward Medical Officer of admission. Do a history and physical on SF 539 if not previously done.

2. RECEIVE REPORT

2. Medical personnel transferring patient will give report to Ward Nurse.

2.1 Diagnosis.

2.2 Surgery or other procedures performed.

2.3 Lab tests and their results.

2.4 Locate and report status of all dressings, drains, tubes, and invasive lines, etc.

2.5 Complications.

2.6 Medications given.

	2.7	IV fluids.
	2.8	Intake and output.
3. REVIEW DOCTORS ORDERS	3.	Review orders with medical person transferring patient.
	3.1	Check orders for accuracy.
	3.2	Verify if STAT orders have been instituted.
4. TRANSCRIBE DOCTORS ORDERS	4.	Charge Nurse will transcribe Physician orders.
	4.1	Transcribe orders to Patient Profile and Patient Care Plan.
	4.2	Add patient's name to ward and TPR logs.
5. ORDER DIETS	5.	Prior to 0400 daily send Ward Diet Roster Form to Service (See Food Department TAB C-8).
	5.1	For admissions, discharges, or changes in diet, call the Food Service Department (See TAB C-8).
6. ORDER IV ADDITIVES	6.	Send Intravenous IV Additive Order Form to Pharmacy IV to order additives.

7. ORDER WARD STOCK DRUGS	7.	Send Drug Requisition Sheet to Pharmacy by 1000 daily to order ward stock drugs. Requisition will be filled by 1500.
	7.1	For emergency drugs, Pharmacy will fill upon request.
	7.2	Return outdated drugs tp Pharmacy for disposal.
8. INVENTORY CONTROLLED SUBSTANCES	8.	At change of watch, on-coming and off-going charge nurses will inventory controlled substances (See TAB C-4).
9. CSR ITEMS	9.	Contaminated items from other hospital areas.

* The using department will take items from other hospital areas to the CSR Support Module.

* The Collection/Reissue HM in the CSR Support Module will receive all items.

* The Collection/Reissue Hm in the CSR Support Module will pull Custody Card/Inventory Lists for instrument trays loaned from CSR to other hospital areas.

* Jointly inventory the tray with person returning the tray/equipment.

* Note any missing items.

* Record and set aside any damaged item IAW the SOP for repair procedures.

* Both persons will sign the Custody Card/Inventory List.

10. REPORT TO PCC VIA TWENTY-FOUR HOUR NURSING REPORT.

10. The charge nurse on each watch will complete the 24 Hour Nursing Report (see TAB C-5).

10.1 Record all ward patient admissions and changes to status on the 24 Hour Nursing Report.

10.2 Include all patient on VSL/SL on report.

11. ADMINISTER EMERGENCY CARE must

11. In the event of a cardiac arrest all personnel be able to:

11.1 Rapidly obtain and assemble all emergency equipment and medications.

11.1.A Locate cardio resuscitation kit.

11.1.B Locate supplemental drug box.

11.1.C Turn power on defibrillator.

11.2 Follow cardiac arrest protocol IAW TAB C-1.

11.3 Assist with

		defibrillation IAW TAB C-2.
12. CARE FOR DECEASED PATIENT	12.	Care for deceased patient IAW nursing procedure manual, TAB F-1.
	12.1	Prepare Notice of Death, NAVMED 6320/5 which the ward medical officer must sign.
	12.2	Record in nursing notes, time of death, medical officer making the pronouncement, and the name of individual contacted to secure deceased's personal effects.
	12.3	Prepare body. See TAB F-1, Nursing Procedures Manual.
	12.3.A	Call lab for body bag.
	12.4	Notify the Command Duty Officer, Chaplain, Patient Care Coordinator, and Ward Medical Officer.
13. ASSIGN WARD PERSONNEL	13.	Charge nurse will make patient assignments.
	13.1	Senior corpman will assign corpman to the following:

	13.1.A	Chow times.
	13.1.B	Ward meals /nourishments.
	13.1.C	Messenger service to laboratory, pharmacy, and CSR.
	13.1.D	Laundry.
	13.1.E	Cleaning details.
14. PERFORM LEADERSHIP and TASKS to staff clinical and	14.	Provide training supervision enhance administrative abilities.
	14.1	Orient staff to wards IAW SOP.
	14.1.A	Provide ongoing training classes to enhance clinical skills and judgements.
15. SUPERVISE/COUNSEL will ward personnel.	15.1.	Charge nurse supervise
	15.2.	Provide performance counselling.
16. MONITOR INCIDENT REPORTS	16.	Monitor any incident reports, counsel as required, and provide classes related to the incident.

H. **STANDARD OPERATING PROCEDURES**: N/A.

I. **CLINICAL POLICIES/GUIDELINES**: See TAB D, page 87.

J. **STANDARDS AND JOB DESCRIPTIONS**: See TAB E, page 101.

K. **DOCUMENTATION**:

1. References: See TAB F, page 123.

2. Forms: See TAB G, page 124.

TAB A

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER INDEX

TAB A-1

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #1

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31037	Charge Nurse	2900/0940	0-4	1*
31013	Asst. Charge Nurse	2900/0940	0-3	2
31183	Staff Nurse	2900/0944	0-3	1
31171	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
36133	Ward Medical Officer	2100/0102	0-4	1*
36069	Asst. Ward Medical Officer	2100/0101	0-3	2+
3. Hospital Corpsman.				
44019	Senior Corpsman	0000/HM	E-6	1*
31045	Asst. Senior Corpsman	0000/HM	E-5	2
31047	General Duty	0000/HM	E-5	1
31223	General Duty	0000/HM	E-3	1
31225	General Duty	0000/HM	E-3	1
31227	General Duty	0000/HM	E-3	1
31229	General Duty	0000/HM	E-3	2
31231	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 1 and 2 per watch.

TAB A-2

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #2

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31039	Charge Nurse	2900/0940	0-4	1*
31014	Asst. Charge Nurse	2900/0940	0-4	2
31185	Staff Nurse	2900/0944	0-3	1
31173	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
36133	Ward Medical Officer	2100/0102	0-4	1*
36069	Asst. Ward Medical Officer	2100/0101	0-3	2+
3. Hospital Corpsman.				
31048	Senior Corpsman	0000/HM	E-5	1*
31049	Asst. Senior Corpsman	0000/HM	E-5	2
44039	General Duty	0000/HM	E-5	1
31233	General Duty	0000/HM	E-3	1
31235	General Duty	0000/HM	E-3	1
31237	General Duty	0000/HM	E-3	1
31239	General Duty	0000/HM	E-3	2
31241	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 1 and 2 per watch.

TAB A-3

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #3

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31041	Charge Nurse	2900/0940	0-4	1*
31015	Asst. Charge Nurse	2900/0940	0-3	2
31187	Staff Nurse	2900/0944	0-3	1
31175	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
36135	Ward Medical Officer	2100/0102	0-4	1*
36071	Asst. Ward Medical Officer	2100/0101	0-3	2+
3. Hospital Corpsman.				
31051	Senior Corpsman	0000/HM	E-5	1*
31052	Asst. Senior Corpsman	0000/HM	E-5	2
44041	General Duty	0000/HM	E-5	1
31243	General Duty	0000/HM	E-3	1
31245	General Duty	0000/HM	E-3	1
31247	General Duty	0000/HM	E-3	1
31241	General Duty	0000/HM	E-3	2
31251	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 3 and 4 per watch.

TAB A-4

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #4

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31043	Charge Nurse	2900/0940	0-4	1*
31017	Asst. Charge Nurse	2900/0940	0-3	2
31189	Staff Nurse	2900/0944	0-3	1
31177	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
36135	Ward Medical Officer	2100/0102	0-4	1*
36071	Asst. Ward Medical Officer	2100/0101	0-3	2+
3. Hospital Corpsman.				
31053	Senior Corpsman	0000/HM	E-5	1*
31054	Asst. Senior Corpsman	0000/HM	E-5	2
31253	General Duty	0000/HM	E-3	1
31255	General Duty	0000/HM	E-3	1
31257	General Duty	0000/HM	E-3	1
31259	General Duty	0000/HM	E-3	1
31261	General Duty	0000/HM	E-3	2
44059	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 3 and 4 per watch.

TAB A-5

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #5

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31045	Charge Nurse	2900/0940	0-4	1*
31019	Asst. Charge Nurse	2900/0940	0-3	2
31191	Staff Nurse	2900/0944	0-3	1
31179	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
36029	Ward Medical Officer	2100/0102	0-6	1+
36137	Asst. Ward Medical Officer	2100/0101	0-4	2+
3. Hospital Corpsman.				
31055	Senior Corpsman	0000/HM	E-5	1*
31057	Asst. Senior Corpsman	0000/HM	E-5	2
31263	General Duty	0000/HM	E-3	1
31265	General Duty	0000/HM	E-3	1
31267	General Duty	0000/HM	E-3	1
31269	General Duty	0000/HM	E-3	1
31271	General Duty	0000/HM	E-3	2
44061	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 5 and 6 per watch.

TAB A-6

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #6

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31047	Charge Nurse	2900/0940	0-4	1*
31021	Asst. Charge Nurse	2900/0940	0-3	2
31193	Staff Nurse	2900/0944	0-3	1
31181	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
36029	Ward Medical Officer	2100/0102	0-6	1+
36137	Asst. Ward Medical Officer	2100/0101	0-4	2+
3. Hospital Corpsman.				
31061	Senior Corpsman	0000/HM	E-5	1*
31062	Asst. Senior Corpsman	0000/HM	E-5	2
31273	General Duty	0000/HM	E-3	1
31275	General Duty	0000/HM	E-3	1
31277	General Duty	0000/HM	E-3	1
31279	General Duty	0000/HM	E-3	1
31281	General Duty	0000/HM	E-3	2
44063	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 5 and 6 per watch.

TAB A-7

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #7

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31025	Charge Nurse	2900/0940	0-3	1*
31027	Asst. Charge Nurse	2900/0940	0-3	2
31195	Staff Nurse	2900/0944	0-3	1
31197	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
36089	Ward Medical Officer	2100/0102	0-6	1+
36159	Asst. Ward Medical Officer	2100/0101	0-3	2+
3. Hospital Corpsman.				
31064	Senior Corpsman	0000/HM	E-5	1*
31065	Asst. Senior Corpsman	0000/HM	E-5	2
31283	General Duty	0000/HM	E-3	1
31285	General Duty	0000/HM	E-3	1
31287	General Duty	0000/HM	E-3	1
31289	General Duty	0000/HM	E-3	1
31291	General Duty	0000/HM	E-3	2
44065	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 7 and 8 per watch.

TAB A-8

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #8

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31065	Charge Nurse	2900/0940	0-4	1*
31067	Asst. Charge Nurse	2900/0940	0-3	2
31199	Staff Nurse	2900/0944	0-3	1
31203	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
36089	Ward Medical Officer	2100/0102	0-6	1+
36159	Asst. Ward Medical Officer	2100/0101	0-3	2+
3. Hospital Corpsman.				
31066	Senior Corpsman	0000/HM	E-5	1*
31068	Asst. Senior Corpsman	0000/HM	E-5	2
31293	General Duty	0000/HM	E-3	1
31295	General Duty	0000/HM	E-3	1
31297	General Duty	0000/HM	E-3	1
31299	General Duty	0000/HM	E-3	1
31301	General Duty	0000/HM	E-3	2
44067	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 7 and 8 per watch.

TAB A-9

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #9

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31071	Charge Nurse	2900/0940	0-3	1*
31075	Asst. Charge Nurse	2900/0940	0-3	2
31201	Staff Nurse	2900/0944	0-3	1
31209	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
36109	Ward Medical Officer	2100/0102	0-5	1+
36161	Asst. Ward Medical Officer	2100/0101	0-3	2+
3. Hospital Corpsman.				
31073	Senior Corpsman	0000/HM	E-5	1*
31071	Asst. Senior Corpsman	0000/HM	E-4	2
31303	General Duty	0000/HM	E-3	1
31305	General Duty	0000/HM	E-3	1
31307	General Duty	0000/HM	E-3	1
31309	General Duty	0000/HM	E-3	1
31311	General Duty	0000/HM	E-3	2
34067	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 9 and 10 per watch.

TAB A-10

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #10

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31079	Charge Nurse	2900/0940	0-3	1*
31083	Asst. Charge Nurse	2900/0940	0-3	2
31205	Staff Nurse	2900/0944	0-3	1
31211	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
36109	Ward Medical Officer	2100/0102	0-4	1+
36161	Asst. Ward Medical Officer	2100/0101	0-4	2+
3. Hospital Corpsman.				
31074	Senior Corpsman	0000/HM	E-5	1*
31076	Asst. Senior Corpsman	0000/HM	E-5	2
31313	General Duty	0000/HM	E-3	1
31315	General Duty	0000/HM	E-3	1
31317	General Duty	0000/HM	E-3	1
31319	General Duty	0000/HM	E-3	1
31321	General Duty	0000/HM	E-3	2
34065	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 9 and 10 per watch.

TAB A-11

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #11

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31089	Charge Nurse	2900/0940	0-3	1*
31091	Asst. Charge Nurse	2900/0940	0-3	2
31207	Staff Nurse	2900/0944	0-3	1
31213	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
44029	Ward Medical Officer	2100/0102	0-5	1+
36163	Asst. Ward Medical Officer	2100/0101	0-4	2+
3. Hospital Corpsman.				
31077	Senior Corpsman	0000/HM	E-5	1*
31081	Asst. Senior Corpsman	0000/HM	E-5	2
31323	General Duty	0000/HM	E-3	1
31325	General Duty	0000/HM	E-3	1
31327	General Duty	0000/HM	E-3	1
31329	General Duty	0000/HM	E-3	1
31331	General Duty	0000/HM	E-3	2
34065	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 11 and 12 per watch.

TAB A-12

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #12

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31095	Charge Nurse	2900/0940	0-3	1*
31099	Asst. Charge Nurse	2900/0940	0-3	2
31215	Staff Nurse	2900/0944	0-3	1
31217	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
44029	Ward Medical Officer	2100/0102	0-5	1+
36163	Asst. Ward Medical Officer	2100/0101	0-3	2+
3. Hospital Corpsman.				
31085	Senior Corpsman	0000/HM	E-5	1*
31088	Asst. Senior Corpsman	0000/HM	E-5	2
31333	General Duty	0000/HM	E-3	1
31335	General Duty	0000/HM	E-3	1
31337	General Duty	0000/HM	E-3	1
31339	General Duty	0000/HM	E-3	1
31341	General Duty	0000/HM	E-3	2
34061	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 11 and 12 per watch.

TAB A-13

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #13

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31103	Charge Nurse	2900/0940	0-3	1*
31107	Asst. Charge Nurse	2900/0940	0-3	2
31221	Staff Nurse	2900/0944	0-3	1
31219	Staff Nurse	2900/0944	0-2	2
2. Medical Corps.				
44049	Ward Medical Officer	2100/0102	0-5	1+
44069	Asst. Ward Medical Officer	2100/0101	0-4	2+
3. Hospital Corpsman.				
31089	Senior Corpsman	0000/HM	E-5	1*
31093	Asst. Senior Corpsman	0000/HM	E-5	2
31343	General Duty	0000/HM	E-3	1
31345	General Duty	0000/HM	E-3	1
31347	General Duty	0000/HM	E-3	1
31349	General Duty	0000/HM	E-3	1
31351	General Duty	0000/HM	E-3	2
34059	General Duty	0000/HM	E-3	2

Permanent watchstander.
Covers Wards 13 and 14 per watch.

TAB A-14

PERSONNEL ASSIGNED BY BILLET SEQUENCE NUMBER

Department: ACUTE CARE WARDS
Ward #14

Billet Number	Title	Designator/ Specialty Code	Rank/ Rate	Watch Section
1. Nurse Corps.				
31111	Charge Nurse	2900/0940	0-3	1*
31115	Asst. Charge Nurse	2900/0940	0-3	2
31227	Staff Nurse	2900/0944	0-3	1
31223	Staff Nurse	2900/0944	0-2	2
34049	Psychiatric Nurse	2900/1930	0-3	1
2. Medical Corps.				
44049	Ward Medical Officer	2100/0102	0-4	1+
44069	Asst. Ward Medical Officer	2100/0101	0-4	2+
3. Hospital Corpsman.				
34019	Senior Corpsman	0000/HM	E-5	1*
31094	Asst. Senior Corpsman	0000/HM	E-5	2
31097	General Duty	0000/HM	E-3	1
31353	General Duty	0000/HM	E-3	1
31355	General Duty	0000/HM	E-3	1
31357	General Duty	0000/HM	E-3	1
31359	General Duty	0000/HM	E-3	2
31361	General Duty	0000/HM	E-3	2
4. Neuro Psychiatric Tech.				
41021	LPO NP Tech	8485	E-5	1*
41043	NP Tech	8485	E-3	1
41045	NP Tech	8485	E-3	2

Permanent watchstander.
Covers Wards 13 and 14 per watch.

TAB B

WATCH BILL INDEX

TAB B-1

WATCH BILL FOR WARD ONE

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
36133	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36064	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31037	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31013	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31183	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31171	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
44019	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31045	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
31047	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31223	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31225	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31227	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31229	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
31231	N	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-2

WATCH BILL FOR WARD TWO

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
36133	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36064	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31039	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31014	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31185	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31173	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
31048	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31049	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
44039	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31233	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31235	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31237	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31239	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
31241	N	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-3

WATCH BILL FOR WARD THREE

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
36135	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36071	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31041	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31015	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31187	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31175	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
31051	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31052	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
44041	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31243	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31245	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31247	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31241	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
31251	N	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-4

WATCH BILL FOR WARD FOUR

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
36135	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36071	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31043	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31017	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31189	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31177	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
31053	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31054	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
31253	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31255	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31257	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31259	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31261	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
44059	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-5

WATCH BILL FOR WARD FIVE

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
36029	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36137	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31045	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31019	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31191	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31179	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
31055	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31057	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
31263	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31265	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31267	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31269	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31271	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
44061	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-6

WATCH BILL FOR WARD SIX

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
36029	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36137	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31047	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31021	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31193	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31181	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
31061	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31062	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
31273	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31275	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31277	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31279	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31281	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
44063	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-7

WATCH BILL FOR WARD SEVEN

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
36089	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36159	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31025	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31027	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31195	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31197	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
31064	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31065	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
31283	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31285	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31287	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31289	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31291	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
44065	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-8

WATCH BILL FOR WARD EIGHT

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
36089	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36159	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31065	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31067	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31199	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31203	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
31066	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31068	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
31293	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31295	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31297	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31299	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31301	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
44067	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-9

WATCH BILL FOR WARD NINE

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
36109	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36161	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31071	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31075	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31201	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31209	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
31073	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31071	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
31303	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31305	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31307	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31309	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31311	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
34067	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-10

WATCH BILL FOR WARD TEN

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
36109	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36161	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31079	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31083	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31205	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31211	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
31074	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31076	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
31313	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31315	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31317	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31319	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31321	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
34065	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-11

WATCH BILL FOR WARD ELEVEN

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
44029	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36163	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31087	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31091	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31207	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31213	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
31077	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31081	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
31323	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31325	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31327	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31329	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31331	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
34063	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-12

WATCH BILL FOR WARD TWELVE

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
44029	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
36163	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31095	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31099	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31215	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31217	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
31085	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31088	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
31333	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31335	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31337	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31339	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31341	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
34061	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-13

WATCH BILL FOR WARD THIRTEEN

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
44049	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
44069	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31103	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31107	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31221	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31219	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
31089	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31093	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
31343	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31345	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31347	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31349	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31351	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
34059	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB B-14

WATCH BILL FOR WARD FOURTEEN

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Medical Officers.																					
44049	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N	E	D
44069	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A	D	E
Nurse Corps.																					
31111	A	E	D	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N
31115	N	D	E	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A
31227	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N	N	N
31223	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A	A	A
Hospital Corpsman.																					
34019	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31094	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A
31097	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E
31353	A	A	A	A	A	A	A	E	D	A	A	A	A	A	A	E	D	N	N	N	N
31355	A	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N	N	N
31357	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	A	A
31359	A	A	D	E	A	A	A	A	A	A	D	E	A	A	A	A	A	A	D	E	N
31361	N	N	N	N	N	N	N	D	E	N	N	N	N	N	N	D	E	A	A	A	A

KEY:
A = AM watch (0700-1900).
N = Night watch (1900-0700).
E = Excused.
D = Duty.

TAB C

STANDARD OPERATING PROCEDURES INDEX

TAB C-1

CARDIAC ARREST PROCEDURE

A. **POLICY**: In the event of sudden cessation of breath, heartbeat, or both, every effort shall be made to re-establish respiratory and/or circulatory function as soon as possible. Cardiopulmonary resuscitation shall be initiated in each incident, unless counter-manded by a Medical Officer, or by written order in the patient's record.

B. **PROCEDURE**:

1. After assessment of cardiac or respiratory arrest is made, immediately initiate basic life support.

(a) Verify unresponsiveness.

(b) Call for help.

(c) If unresponsive, open the airway.

(d) Check for breathing.

(e) If not breathing, give 2 full ventilations, 1 to 1 ½ seconds each.

(f) Check carotid pulse.

(g) If pulse is absent, start chest compressions, 80 - 100 per minute.

2. Have second person call arrest team.

(a) Pick up Field Phone and state "Code Blue" on Ward _____.

(b) Communication personnel will announce over PA system "Code Blue" on Ward_____.

3. Have second or third person bring emergency equipment to the scene.

(a) Emergency Cardio Resuscitation Kit.

(b) Oxygen cylinder.

(c) Suction machine with all catheters attached.

4. Members of arrest team will:

(a) Perform chest compression (one member).

(b) Manage airway and do ventilation (one member).

(c) Start an IV.

(d) Draw up and administer medications as directed by ACLS certified member or Medical Officer (one member).

(e) Document arrest on Cardiac Arrest Flow Sheet. This member will be the same throughout the emergency.

C. **VITAL POINTS**:

1. Basic life support must not be interrupted for more than 5 seconds.

2. Advanced life support is only effective if proper basic life support is initiated and maintained.

3. Complete, specific nursing notes showing the exact time of events on Cardiac Arrest Flow Sheet.

4. Arrival of the arrest team does not relieve nursing personnel of responsibility. (The units must perform coordinated, complimentary functions.)

D. **EDUCATION REQUIREMENTS**:

1. All medical personnel must maintain Basic Cardiac Life Support (BCLS) certification.

2. All medical officers and Critical Care Area Nurses should maintain advanced Cardiac Life Support (ACLS) certification.

3. CPR drills will be conducted monthly on all nursing wards in order to assure medical personnel awareness of their role in a code.

TAB C-2

DEFIBRILLATION

A. **PURPOSE:** To terminate ventricular fibrillation immediately, facilitating the establishment of an effective cardiac rhythm. This is the first and only treatment for ventricular fibrillation.

B. **DEFINITION:** Also known as precordial shock, it is the conduction of an electrical impulse into the heart to depolarize cardiac muscle and convert fibrillation rhythm into normal sinus rhythm.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED**:

1. Defibrillator with external paddles.
2. Batteries.
3. ECG monitor with recorder.
4. Conductive medium.
5. Cardio Resuscitation Kit (Sparks Kit).
6. Oxygen therapy equipment.
7. Airways.
8. Endotracheal Anesthesia Set.
9. AMBU bag.
10. Suctioning equipment.

D. **CRITERIA:**

1. Conversion of an abnormal rhythm following a precordial thump or cough has been well demonstrated in patients with ventricular tachycardia and complete heart block. Recently, it has been demonstrated as well for ventricular fibrillation. Because the speed of defibrillation is critical, a solitary precordial thump is recommended for all witnessed cardiac arrests when a defibrillator is unavailable. When a precordial thump is used in patients who have ventricular tachycardia and a pulse, a defibrillator should be available since ventricular fibrillation can be

induced. A precordial thump is delivered to the center of the sternum with the hypothenar aspect of the fist and from a height of no more than 12 inches.

2. Defibrillator battery will be charged and ready to use at all times.

3. Person in charge of the arrest will insure all personnel stand clear so that only the patient will receive the electrical current when “ALL CLEAR” is called.

E. **STEPS**:

1. Initiate basic cardiac life support (BCLS) and summon defibrillation equipment and assistance.

2. Verify ventricular fibrillation by ECG. Correlate with the clinical state of patient.

(a) Establish an airway or use existing endotracheal tube if in place.

(b) Perform external cardiac massage until defibrillator is ready. In the OR, internal cardiac massage may be necessary.

(c) When patients are monitored and defibrillation equipment is available, proceed with defibrillation.

3. Prepare to defibrillate.

(a) Obtain battery operated defibrillator.

(b) Check battery level.

(c) Prepare defibrillator paddles by covering entire metal surface with conductive medium. (The conductive medium is needed to reduce skin resistance to current flow, prevent skin burns, and allow for optimal current flow to the myocardium.)

(d) Dial 200 watts/seconds (Joules).

(e) Activate charge button to charge unit with electrical current.

(f) Validate that defibrillator unit is in the non-synchronized mode so machine will fire correctly.

(g) Place paddles firmly into position against chest wall using 25-30 pounds of pressure.

(1) Best position - transverse position.

a Place one paddle at 2nd intercostal space right of sternum.

b Place second paddle at 5th intercostal space mid-clavicular line, left of sternum.

(2) Alternate position - anterior-posterior position.

a Place one paddle at anterior-precordial area.

b Place 2nd paddle at posterior-intrascapular area.

(h) Recheck ECG rhythm on cardioscope to validate Ventricular fibrillation pattern.

(i) Give command to stand clear of bed/litter/OR table prior to defibrillation to minimize risk of micro or macro shock to staff.

4. Defibrillate the patient.

(a) Depress the discharge button while simultaneously keeping both paddles in place until the electrical current is delivered.

(b) Check ECG rhythm on cardioscope for changes in pattern.

(1) If ventricular fibrillation persists, repeat defibrillation immediately.

(2) Continue CPR during any delays in defibrillation.

(3) If a second attempt is unsuccessful, immediately defibrillate with up to 360 Joules.

(4) If the ECG monitor shows an organized rhythm, check for a pulse. Continue CPR if no pulse present.

(5) If unsuccessful, continue with current ACLS

protocol.

VENTRICULAR FIBRILLATION [a]

This sequence was developed to assist in teaching how to treat a broad range of patients with ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT). Some patients may require care not specified herein. This algorithm should not be construed as prohibiting such flexibility. The flow of the algorithm presumed that VF is continuing. CPR indicates cardiopulmonary resuscitation.

Witnessed Arrest	Unwitnessed Arrest
Check pulse - If no pulse	Check pulse - If no pulse
Precordial Thump	
Check pulse - If no pulse	

CPR until a defibrillator is available

Check monitor for rhythm - if VF or VT

Defibrillate, 200 Joules [b]

Defibrillate, 200-300 Joules [b]

Defibrillate with up to 360 Joules [b]

CPR if no pulse

Establish IV access

Epinephrine, 1:10,000, 0.5-1.0 mg IV push [c]

Intubate if possible [d]

Defibrillate with up to 360 Joules [b]

Lidocaine, 1 mg/kg IV push

Defibrillate with up to 360 Joules [b]

Bretylium, 5mg/kg IV push [e]

(Consider Bicarbonate)[f]

Defibrillate with up to 360 Joules [b]

Bretylium, 10 mg/kg IV push [e]

Defibrillate with up to 360 Joules [b]

Repeat Lidocaine or Bretylium

Defibrillate with up to 360 Joules [b]

NOTES:

1. Pulseless ventricular tachycardia should be treated identically to ventricular fibrillation.

2. Check pulse and rhythm after each shock. If VF recurs after transiently converting (rather than persists without ever converting), use whatever energy level has previously been successful for defibrillation.

3. Epinephrine infusion should be repeated every five (5) minutes.

4. Intubation is preferable. If it can be accomplished simultaneously with other techniques, then the earlier the better. However, defibrillation and epinephrine are more important initially if the patient can be ventilated without intubation.

5. Some may prefer repeated doses of lidocaine, which may be given in 0.5 mg/kg douses every 8 minutes to a total dose of 3 mg/kg.

6. The value of sodium bicarbonate is questionable during cardiac arrest, and it is not recommended for the routine cardiac arrest sequence. Consideration of its use in a dose of l mEg/kg is appropriate at this point. One half of the original dose may be repeated every 10 minutes if it is used.

SUSTAINED VENTRICULAR TACHYCARDIA

This sequence was developed to assist in teaching how to treat a broad range of patients with sustained ventricular tachycardia (VT). Some patients may require care not specified herein. This algorithm should not be construed as

prohibiting such flexibility. The flow of the algorithm presumes that VT is continuing. VF indicates ventricular fibrillation; IV, intravenous.

No Pulse	Pulse Present	
Treat as VF	Stable	Unstable
	O_2	O_2
	IV Access	IV Access
	Lidocaine, 1 mg/kg	(Consider sedation)[c]
0.5 mg/kg every	Lidocaine, 50 Joules [d,e]	Cardiovert,
	8 min. until VT resolves, or up to 3 mg/kg.	Cardiovert, 100 Joules [d]
	Procainamide, 20 mg/min until VT resolves, or up to 1,000 mg.	Cardiovert, 200 Joules [d]
		Cardiovert, with up to 360 Joules [d]
	Cardiovert as in unstable patients [c]	If recurrent, add Lidocaine and cardiovert again starting at energy level previously successful; then procainamide or Bretylium.

NOTES:

1. If the patient becomes unstable (see Footnote b for definition) at any time, move to the “Unstable” arm of the algorithm.

2. Unstable = symptoms (e.g. chest pain, dyspnea), hypotension (systolic BP <90 mm Hg), congestive heart failure, ischemia, or infarction.

3. Sedation should be considered for all patients, including those defined in Footnote b as unstable, except those who are hemodynamically unstable (e.g., hypotensive, in pulmonary edema, or unconscious).

4. If hypotension, pulmonary edema, or unconsciousness is present, unsynchronized cardioversion should be done to avoid the delay associated with synchronization.

5. In the absence of hypotension, pulmonary edema, or unconsciousness, a precordial thump may be employed prior to cardioversion.

6. Once VT has resolved, begin an IV infusion of the antiarrhythmic agent that has aided the resolution of the VT. If hypotensive, in pulmonary edema, or unconscious, use lidocaine if cardioversion alone is unsuccessful, followed by bretylium. In all other patients, the recommended order of therapy is lidocaine, procainamide, and the bretyulium.

ASYSTOLE (CARDIAC STANDSTILL)

This sequence was developed to assist in teaching how to treat a broad range of patients with asystole. Some patients may require care not specified herein. This algorithm should not be construed to prohibit such flexibility. The flow of the algorithm presumes asystole is continuing. CPR indicates cardiopulmonary resuscitation; VF, ventricular fibrillation; IV, intravenous. If rhythm is unclear and possibly ventricular
fibrillation, defibrillate as for VF. If Asystole is present: [a]

Continue CPR

Establish IV access

Epinephrine, 1:10,000, 0.5-1.0 mg IV push [b]

Intubate when possible [c]

Atropine, 1.0 mg IV push (repeated in 5 min)

(Consider bicarbonate) [d]

Consider pacing

NOTES:

1. Asystole should be confirmed in two leads.

2. Epinephrine should be repeated every 5 minutes.

3. Intubation is preferable; if it can be accomplished simultaneously with other techniques, then the earlier the better. However, CPR and the use of epinephrine are more important initially if the patient can be ventilated without intubation. (Endotracheal epinephrine may be used.)

4. The value of sodium bicarbonate is questionable during cardiac arrest, and it is not recommended for the routine cardiac arrest sequence. Consideration of its use in a dose of 1mEg/kg is appropriate at this point. One half of the original dose may be repeated every 10 minutes if it is used.

ELECTROMECHANICAL DISSOCIATION

This sequence was developed to assist in teaching how to treat a broad range of patients with electromechanical dissociation (EMD). Some patients may require care not specified herein. This algorithm should not be construed to prohibit such flexibility. The flow of the algorithm presumes that EMD is continuing. CPR indicates cardiopulmonary resuscitation; IV, intravenous.

Continue CPR

Establish IV access

Epinephrine, 1:10,000, 0.5-1.0 mg IV push [a]

Intubate when possible [b]

(Consider bicarbonate) [c]

Consider Hypovolemia,
Cardiac Tamponade,
Tension Pneumothorax,
Hypoxemia,
Acidosis,
Pulmonary Embolism

NOTES:

1. Epinephrine infusion should be repeated every 5 minutes.

2. Intubation is preferable. If it can be accomplished simultaneously with other techniques, then the earlier the better. However, epinephrine is more important initially if the patient can be ventilated without intubation.

3. The value of sodium bicarbonate is questionable during cardiac arrest, and it is not recommended for the routine cardiac arrest sequence. Consideration of its use in a dose of 1 mEg/kg is appropriate at this point. One half of the original dose may be repeated every 10 minutes if it is used.

PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA

This sequence was developed to assist in teaching how to treat a broad range of patients with sustained PSVT. Some patients may require care not specified herein. This algorithm should be not construed as prohibiting such flexibility. The flow of the algorithm presumes PSVT is continuing.

Unstable	Stable
Synchronous Cardioversion 75 - 100 Joules	Vagal Maneuvers
Synchronous Cardioversion 200 Joules	Verapamil, 5 mg IV
Synchronous Cardioversion 360 Joules	Verapamil, 10 mg IV (in 15-20 min)
Correct underlying abnormalities	Cardioversion, Digoxin B-Blockers, Pacing as Indicated
Pharmacological Therapy - Cardioversion	

If conversion occurs but PSVT recurs, repeated electrical cardioversion is <u>not</u> indicated. Sedation should be used as time permits.

BRADYCARDIA

This sequence was developed to assist in teaching how to treat a broad range of patients with bradycardia. Some patients may require care not specified herein. This algorithm should not be construed to prohibit such flexibility. A-V indicates atrioventricular.

Slow Heart Rate (<60 beats/min) [a]

Sinus or Junctional Block

Second Degree A-V Block Type I

Second Degree A-V Block Type II

Third Degree A-V Block

Signs or Symptoms [b]

No

Yes

No

Observe

Atropine, 0.5-1.0 mg Transvenous Pacemaker

Continued Signs and Symptoms b

No

Yes

For Second Degree Type II or Third Degree:

For Second Degree Type I, sinus or junctional:

Repeat Atropine, 0.5-1.0 mg.

Continued Signs/Symptoms [b]

Transvenous Pacemaker

Yes

Observe

External Pacemaker [c]
or
Isoproterenol, 2-10 mg/min [c]

Transvenous Pacemaker

NOTES:

1. A solitary chest thump or cough may stimulate cardiac electrical activity and result in improved cardiac output and may be used at this point.

2. Hypotension (BP <90 mm Hg), PVCs, altered mental status or symptoms (e.g., chest pain, dyspnea), ischemia, or infarction.

3. Temporizing therapy.

VENTRICULAR ECTOPY:
ACUTE SUPPRESSIVE THERAPY

This sequence was developed to assist in teaching how to treat a broad range of patients with ventricular ectopy. Some patients may require therapy not specified herein. This algorithm should not be construed as prohibiting such flexibility.

Assess for need for
Acute Suppressive Therapy

Rule out treatable cause
Consider serum potassium
Consider digitalis level
Consider bradycardia
Consider drugs

Lidocaine, 1 mg/kg

If not suppressed, repeat lidocaine,
0.5 mg/kg every 2-5 min. until no ectopy,
or up to 3 mg/kg given

If not suppressed, procainamide 20 mg/min
until no ectopy, or up to 1,000 mg given

If not suppressed, and not contraindicated,
bretylium, 5-10 mg/kg over 8-10 min.

If not suppressed, consider overdrive pacing

Once ectopy resolved, maintain as follows:

After Lidocaine, 1 mg/kg	Lidocaine drip, 2 mg/min
After Lidocaine, 1-2 mg/kg	Lidocaine drip, 3 mg/min
After Lidocaine, 203 mg/kg	Lidocaine drip, 4 mg/min

After Procainamide	Procainamide drip, 1-4 mg/min (check blood level)
After Bretylium	Bretylium drip, 2 mg/min

(6) Assess patient status and precipitating factors to prevent further decompensation of the patient.

5. Provide post defibrillation care.

(a) Perform a complete base-line physical assessment of patient. Assess vital signs, peripheral pulses, respiratory pattern, and level of consciousness.

(b) Monitor ECG rhythm watching for arrhythmias.

(c) Obtain a 12 lead ECG to assess myocardial damage.

(d) Administer oxygen to reduce hypoxemic state.

(e) Assess chest wall for any burns. Apply Silver Sulfadiazine to any burned areas.

(f) Establish an IV line for medication administration, if not present.

(g) Administer prescribed medications IAW Physician Orders.

(1) Monitor drips of antidysrhythmic drugs (lidocaine) carefully.

(2) Observe patient and ECG pattern for medication effects.

6. Document defibrillation on Cardiac Arrest Flow Sheet. Record the following:

(a) Ventricular fibrillation was observed on monitor. If available, include pre-defibrillation ECG rhythm strip.

(b) Number of times defibrillation was attempted.

(c) Voltage used with each attempt.

(d) Post-defibrillation ECG rhythm. Include an ECG

rhythm strip if available.

(e) Physiological multisystem status.

(f) Death.

F. **PRECAUTIONS**:

1. Check that equipment is properly grounded to prevent current leakage.

2. Disconnect other electrical equipment attached to patient to prevent possible equipment damage from the voltage surge.

3. Use conductive medium on paddles conservatively to prevent over arcing of the current flow to the patient.

4. Clean defibrillator of remaining electrical current immediately after use. Never set charged defibrillator paddles down.

5. Check that defibrillator is in non-synchronized mode such that it is not dependent upon an R wave to trigger defibrillation.

G. **COMPLICATIONS**:

1. Dysrhythmias.

2. Cardiac arrest.

3. Respiratory arrest.

4. Neurological impairment.

5. Altered skin integrity.

6. Pulmonary edema.

7. Pulmonary or systemic emboli.

8. Equipment malfunction.

9. Death.

H. **RESPONSIBILITY**:

1. Medical Officer will defibrillate the patient.

2. Nurse will administer medication, assist with CPR, and record the information in the patient's chart.

3. Hospital Corpsman will inspect and maintain the defibrillator equipment and supplies in working order. Supplies for the Sparks Kit will be obtained from Material Management Department.

I. **REFERENCE**:

1. Interim Guideline for Advanced Cardiac Life Support (ACLS), The American Heart Association.

2. Textbook of Advanced Cardiac Life Support (ACLS), The American Heart Association.

TAB C-3

ROUTINE MEDICATION TIMES

A. **PURPOSE:** To standardize medication administration times so that nursing service and pharmacy can perform this task most efficiently.

B. **SCHEDULE**:

1. Routine times.

(a)	qd	0900
(b)	bid	0900-2100
(c)	tid	0600-1400-2200
(d)	qid	0600-1200-1800-2400
(e)	q4hr	0200-0600-1000-1400 etc
(f)	q6hr	0600-1200-1800-2400
(g)	q8hr	0600-1400-2200
(h)	q3hr	0300-0600-0900 etc
(i)	q12hr	0600-1800
(j)	qhs	2200
(k)	Daily insulin 0700.	
(l)	Insulin sliding scale 0700-1100-1600-2100.	

2. Special considerations for adjusting times.

(a) Triple IV antibiotics are ordered.

(b) Diuretics are ordered: best to administer before 2200.

(c) Oral antibiotics scheduled for 2400 should be given at 2200 so sleep is not interrupted.

C. **CRITERIA**:

Medications will be given at routine times unless adjusted for reason specified.

D. **STEPS**:

1. Complete medication cards and MAR sheet with times stated above.

2. For medication times differing from the routine, note this in margin of Doctor’s Orders Sheet, SF 508, prior to sending to Pharmacy.

E. **RESPONSIBILITY**:

Charge Nurse.

TAB C-4

GUIDELINES FOR ADMINISTRATION OF CONTROLLED SUBSTANCES

A. **PURPOSE:** To provide guidelines for administration of controlled substances.

B. **DEFINITION:** Narcotics and controlled drugs are medications that by law must be stored within a locked system and inventoried for accountability.

C. **EQUIPMENT, SUPPLIES, AND FORMS NEEDED**:

1. Narcotics and controlled drugs.

2. Medication locker with double lock system.

3. NAVMED Form 6710/4.

D. **CRITERIA**:

1. All narcotics and controlled substances will be stored in a medication locker with a double lock.

2. The keys to the medication locker are to be in the personal custody of the registered nurse.

3. All narcotics and controlled substances will be logged out by a registered nurse.

4. All narcotics and controlled substances will be verified each watch concurrently by nurses reporting on and off duty.

E. **STEPS**:

1. Nurses reporting on and off duty will count drugs on hand and verify on each watch.

2. Both Nurses will sign NAVMED 6710/4 Narcotic and Controlled Drug Inventory. Verification will include drug, patient, amount, and serial number.

3. Report any discrepancies to patient care coordinator and pharmacy and file an incident report.

4. Only a registered nurse may receive narcotics and controlled substances delivered by pharmacy personnel.

5. When logging out drugs, complete the following information on NAVMED 6710/4: patients last name, first initial, amount dispensed, ordering physician, person withdrawing, and amount of drug remaining.

6. When using only a portion of the total amount expended, document the amount used, and discard the unused portion with witness present.

7. When a dose is damaged, contaminated, portion wasted, or refused by the patient, destroy the dose. Document the event on 6710/1.

8. The patient care coordinator will inventory and verify drugs on hand monthly. Document on 6710/4.

F. **RESPONSIBILITY**:

1. Charge Nurses.

2. Patient Care Coordinator.

TAB C-5

TWENTY-FOUR HOUR NURSING SERVICE REPORT

A. **PURPOSE:** To provide a written communication of significant patient information to the Director of Nursing Service and the Commanding Officer.

B. **DEFINITION:** N/A.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

1. Twenty-four Hour Nursing Service Report, NAVMED Form 6550/3.

D. **CRITERIA**:

1. The Twenty-Four Hour Nursing Service Report is to be completed by the charge nurse at the end of each watch.

2. Each entry is to be completed in black ink, legible, and concise.

E. **STEPS**:

1. Complete body of report. Include:

(a) Patients name, age, grade, rate, and diagnosis.

(b) Approved abbreviations.

(1) AM (AM watch).

(2) PM (PM watch).

(3) DOS (Day of surgery).

(4) POD (Post-op day).

(5) VSL (Very serious list).

(6) SL (Serious list).

(7) DD (Patient expired).

(8) DOP (Day of significant procedure).

2. Narrative section guidelines.

(a) State brief history.

(b) Give reason for admission, diagnosis.

(c) State significant procedures or surgery performed. Indicate results.

(d) State significant treatments or progress.

3. Use first block for relaying information such as number of expectants, expected air evacs, and staffing needs.

4. List the following patients daily.

(a) Flag officers (0-7).

(b) Captains and colonels (0-6).

(c) Fleet hospital staff regardless of rate or rank.

(d) Foreign military/POW's.

(e) ICU, CCU, and recovery room keeps.

(f) Serious ill (SL) and very serious ill (VSL) patients.

(g) Deaths; include time.

(h) Accident or unusual accurances i.e., drug injection, self-inflicted injury.

(i) Civilian humanitarian.

F. **RESPONSIBILITY**:

Charge nurse.

G. **REFERENCE**:

Nursing Procedure Manual, NAVMED P-5066.

TAB C-6

HAZARDOUS WASTE

A. **PURPOSE:** To provide guidance for the collection, handling and disposal of hospital generated wastes which have contacted living organisms or may otherwise be considered infectious or hazardous.

B. **DEFINITION**:

1. Background: The operation of health care facilities creates waste materials, some of which are hazardous. A subset of hazardous waste is infectious waste; proper handling of infectious waste is mandatory, to prevent spread of infectious diseases. The methods of handling infectious waste, from its generation to its ultimate disposal, must be adhered to strictly by all hands, without exception.

2. Relationship with Host Nations: It is anticipated that the hospital will be operating, in a wartime or conflict mode, on foreign soil. Close liaison with force planners during the pre-deployment planning phase is essential for the hospital command to determine host nation requirements for handling, storage and disposal of infectious hazardous wastes. Whenever possible, agreements and/or contracts with host nations should be secured for the incineration or sanitary burial of wastes in accordance with the host nation's regulations. During peacetime exercises on U.S. soil, adherence to federal, state and local environmental laws and regulations, partially listed in Appendix A, shall be strictly enforced.

3. Categories of Hospital Generated Waste: It must be clearly understood that the field hospital will generate four distinct categories of waste. Each type will require special handling procedures from generation to disposal. These categories are:

(a) Infectious waste - generated in patient contact, laboratory and surgical areas.

(b) Hazardous waste - usually chemical in nature and generated in the Laboratory, X-ray and Public Works department.

(c) Infectious hazardous waste - generated in the laboratory.

(d) Non-infectious waste - generated in all areas of the hospital.

4. Definitions.

(a) Infectious waste is defined as waste originating from the diagnosis and treatment of people. There are five (5) broad categories of infectious waste recognized by the Centers for Disease Control (CDC): microbiological, blood and blood products, pathological, sharps, and isolation waste. Examples of each of these types include, but are not necessarily limited to, the following:

(1) Microbiological - wastes generated in laboratories processing bacterial, fungal, mycobacterial, or viral materials, such as media-containing plates, tubes, or diagnostic strips; swabs; glass slides; pipettes. Live virus vaccines (including smallpox, yellow fever, rubella, measles, mumps, polio, and adenovirus) and any of the associated equipment for their use also fall into this classification.

(2) Blood and blood products - wastes generated in the collection processing, and use of blood and blood products; tubes for diagnostic blood collection; items and materials contaminated with blood or blood products that are not designed for cleaning, resterilization, and reuse.

(3) Pathological - pathologic specimens, body tissues, contaminated disposable instruments, and laboratory waste generated in the performance of medical treatment procedures and diagnostic laboratory testing.

(4) Sharps - any diagnostic or therapeutic item possessing a surface capable of piercing human skin, not designed for cleaning, resterilization, and reuse. Examples would include needles for injections, preparation of intravenous medicinals, indwelling cannulae, and diagnostic testing (e.g., lumbar puncture, thoracentesis, paracentesis, etc.); scalpels; and other disposable instruments with a surface capable of piercing human skin.

(5) Isolation waste - wastes generated in the therapy of patients on isolation precautions. Examples would include gowns; gloves; masks; head covers; dressings; disposables basins; paper towels used in isolation rooms; and other such items and materials used in the care of isolation patients that are not designed for cleaning, resterilization, and reuse.

(b) Fomites - an object or item that is not of itself harmful, but may harbor pathogenic microrganisms and serve as a vehicle in the transmission of infections. Examples would include but are not limited to bedding, linen, cloth towels and washrags, diagnostic medical instruments (e.g., stethoscopes, sphygmomanometers, thermometers), and personal items (e.g., razors, toothbrushes, toiletries).

(c) Hazardous waste - any wastes, or combination of wastes, which because of its quantity, concentration, physical or chemical properties may pose a substantial present or potential threat to human health or the environment when improperly treated, stored, transported, disposed of or otherwise managed.

(d) Infectious hazardous waste - any combination of materials and agents that meet the definitions described in 2-4.a. and 2-4.c. above. These wastes will typically be generated in the laboratory when organic pathogens are combined with hazardous chemicals or reagents.

(e) Non-infectious waste - waste generated from non-clinical spaces and waste from patients and their related procedures, where no infection or contagious disease exists.

(f) Storage - the holding of infectious hazardous waste for a temporary period, at the end of which the waste is treated, disposed of, or stored elsewhere.

(g) Treatment - any method, technique, or process designed to change the chemical, physical, or biological characteristics of any infectious hazardous waste so as to render such waste nonhazardous, or less hazardous or safer for transportation, storage or disposal.

(h) Autoclave - an apparatus using steam under pressure for sterilizing medical equipment.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED**: N/A.

D. **CRITERIA**:

Hazardous waste is properly handled and disposed.

E. **STEPS**:

1. Handling.

(a) Infectious and infectious hazardous waste.

(1) Ward and laboratory personnel shall utilize personal protective clothing and procedures which would normally be practiced in a traditional health care setting for the control of the spread of disease.

(2) Personnel shall wear disposable gloves, gowns, and shoe and hair covers.

(3) Patient contact and laboratory areas will utilize clearly marked, impervious, containers for the disposal of all sharps. When full, the sharps container shall be securely closed with autoclave tape.

(4) Patient areas will utilize clearly marked containers lined with double plastic bags, the outer bag being an orange autoclavable “biological hazard” bag. These containers will be separate from non-infectious “trash” containers. When full, the inner bag will be sealed with autoclave tape. The outer bag will be sealed with filament reinforced tape and autoclave tape.

(b) Hazardous waste.

(1) Protective equipment, as described in DHHS (NIOSH) Publication No. 81-123 (see Appendix A), will be utilized by personnel handling hazardous waste.

(2) All hazardous waste will be containerized. Ideally, in the original container or containers designed for the collection of such wastes such as those provided with automated laboratory equipment.

(3) Containerized and transporting to storage areas will be accomplished by the waste generator (i.e., lab, x-ray, public works, etc.).

2. Transport and storage.

(a) Infectious waste.

(1) Ward personnel will deliver properly sealed sharps containers and double bagged infectious waste, to the laboratory temporary holding area, on a regularly scheduled basis. Ideally, this area will be one of low traffic and prohibitive to patient care, smoking, eating, and food or medicinal handling.

(2) Ideally, ward personnel will store and transport multiple bags of infectious waste in large, covered containers (i.e., “GI” cans with tight fitting lids). These containers shall be scrubbed with a germicidal solution at least once per shift or more often if grossly contaminated.

(3) Laboratory personnel will handle and routinely autoclave waste under steam pressure for a minimum of fifteen (15) minutes. After proper autoclaving, these wastes may be handled as noninfectious depending on host nation requirements.

(b) Hazardous waste.

(1) As noted in paragraphs 3-1 b.2, hazardous waste will be stored in their original containers or those designed for collection of such wastes.

(2) Waste generating personnel will containerize waste according to its chemical grouping such as lubricants, fuels, acids, alkalines, chlorinated hydrocarbons, etc. Containers will be tightly sealed and labeled.

(3) Storage areas will be at least 100 yards from the hospital compound and actual or potential potable water sources. Ideally, these areas will be elevated with natural drainage away from the hospital and water sources. Waste containers should be protected from the elements and the area clearly marked as “Hazardous Waste Storage.”

3. Disposal.

(a) General. It must be understood that, in an operational situation, the methods of waste disposal range form ideal to undesirable. The following disposal methods are intended to guide the hospital command towards utilization of the best disposal method for any given situation.

(1) Host Nation Agreement - Under the Status of Forces Agreement the cognizant Commander-in-Chief (CINC) will negotiate with the host country for disposal services.

(2) The cognizant CINC will provide disposal services utilizing established logistical support channels within the theater of operations such as the Supply Battalion of the Force Service Support Group, or supply ships.

(b) Methods. In the absence of the preferred, above

mentioned disposal methods, the following may be utilized.

(1) Nonhazardous/noninfectious waste (including properly autoclaved infectious waste).

a Burial in a pit as deep as organic equipment will allow and covered with at least two feet of earth. Burial pits should be at least 100 yards from the hospital compound and potable water sources.

b Burning by mixing with fuel oil until only ash remains. Ash should then be buried as above. Tactical consideration must be given to open burning as smoke may give away the hospitals location.

(2) Hazardous waste.

a Laboratory chemical waste which contains infectious, organic matter, is to be treated as hazardous as autoclaving of liquids in closed containers is not authorized.

b Burial in sealed, marked containers, as deep as organic equipment will permit. Burial sites should be lined with plastic sheeting, covered with at least four feet of earth and conspicuously marked. Sites should be at least 100 yards from the hospital compound and potable water sources.

F. **RESPONSIBILITY**:

1. The Commanding Officer is responsible for ensuring the proper management of the overall infectious and hazardous waste program and to interface with the host nation to ensure local regulations are satisfied.

2. Nursing Service via the clinical staff is responsible for the handling of all wastes generated in clinical spaces. This includes ensuring that adequate supplies of hampers, bags, tapes, sharps containers, and protective clothing are maintained in these spaces.

3. Laboratory Service is responsible for handling hazardous infectious wastes once it is delivered to or generated by the laboratory. The service is also responsible for proper autoclaving of such wastes to render it free from pathogens.

4. Surgical Service is responsible for handling wastes generated within the operating room giving special attention

to surgically removed human tissue.

5. Operating Management is responsible for the removal of waste from the central collection points, including the laboratory, and delivery to the designated pickup area such as the “back loading dock.”

6. Public Works Department is responsible for the removal of wastes from the hospital compound and ensuring its proper disposal as outlined in this SOP.

TAB C-8

NON-AMBULATORY PATIENT MEALS

A. **PURPOSE**: To efficiently provide nourishments and meals to bed-ridden patients.

B. **DEFINITION**: N/A.

C. **EQUIPMENT, SUPPLIES AND FORMS REQUIRED**:

1. Ward Diet Roster Form.

2. Twenty-Four Hour Intake and Output Form.

3. Bedside tray for field bed.

4. Types of diet available:

5. High calorie - high protein.

6. Dental soft.

7. Dental liquid.

8. Full liquid.

9. Clear liquid.

10. Forced fluids.

11. Tube feedings.

NOTE: No sodium restricted diets will be provided.

D. **CRITERIA**:

1. Non-ambulatory patient meals are ordered accurately and in time.

2. Three hot meals will be served each twenty-four hour period.

3. Six types of menus are available.

4. Non-infectious patients may assist in feeding non-ambulatory patients.

E. **STEPS**:

1. Order diets.

(a) Prepare a ward diet roster by 0400 each day. Supplies of rosters must be maintained on each ward and may be obtained from operating management service.

(b) Specify appropriate diet from selection of six options.

(c) Complete form as indicated, providing at minimum, patient name, assigned bed, and diet order.

(d) Enter any special requirements as indicated.

(e) Make diet changes by calling food service. Changes will be accepted up to:

(1) 0400 for Breakfast.

(2) 0900 for Lunch.

(3) 1400 for Supper.

2. Prepare patient for meal.

(a) Wash patient's hands and face.

(b) Place patient in an upright, comfortable position.

(c) Clear bedside table and place near patient.

3. Serve tray to patients in accordance with TAB C-8.

4. Assist patient with meal as needed.

5. Record fluids consumed on Twenty-four Hour Intake and Output Form if ordered. Record how diet was tolerated in nursing notes.

6. Give oral hygiene to patients as needed.

F. **RESPONSIBILITY**:

1. Charge Nurse.

2. Senior Corpsman.

G. **REFERENCES**:

1. NAVMED P5066-A.

2. NAVSUP PUB 436, Standard “B” Medical Rations for the Armed Forces.

3. Food Service Department Standard Operating Procedure (Chapter 10).

TAB C-9

WARD MEAL DELIVERY AND RETRIEVAL SCHEDULE/PROCEDURE

A. **PURPOSE:** To promulgate uniform procedures to accomplish non-ambulatory patient meal service.

B. **DEFINITION:** N/A.

C. **CRITERIA**:

1. Meals will be delivered hot to the correct patient on each ward.

2. Meals will be served and cleaned up within one hour of delivery on ward.

D. **STEPS**:

	Ward	Delivery	Pickup
Breakfast	2	0530	0630
	4	0540	0640
	6	0550	0650
	7	0600	0700
	5	0610	0710
	3	0620	0720
	1	0630	0730
Lunch	2	1030	1130
	4	1040	1140
	6	1050	1150
	7	1100	1200
	5	1110	1210
	3	1120	1220
	1	1130	1230
Dinner	2	1630	1730
	4	1640	1740
	6	1650	1750
	7	1700	1800
	5	1710	1810
	3	1720	1820
	1	1730	1830

1. Two Mess Specialists will be assigned at each meal to deliver and serve patient meals. Each MS will be assigned responsibility for specific wards.

(a) MS #1 is responsible for Wards 1, 5, 6, and 2.

(b) MS #2 is responsible for Wards 3, 7, and 4.

2. When the delivery vehicle arrives at each ward, the responsible Mess Specialist will notify the responsible Charge Nurse.

3. Each Ward Charge Nurse will assign a staff corpsman to assist during meal periods.

4. The responsible HM and MS will unload all gear required for each respective ward and carry it into the ward.

5. As each ward is delivered, the vehicle will move on to the next ward in sequence.

6. On the ward, the MS will:

(a) Set up a meal assembly line.

(b) Portion items required to support each diet ordered on the roster.

(c) Leave the remaining material set up on the ward.

(d) Proceed to the next assigned ward.

7. On the ward the HM will:

(a) Present and hold the necessary trays for each patient while the MS portions the meal.

(b) Deliver the meal to the appropriate patient.

(c) Dispense appropriate beverages.

(d) Dispense any remaining food consistent with specific diet orders.

(e) Retrieve soiled gear.

(f) Stage soiled gear adjacent to the exit vestibule for subsequent pick up by MS.

8. Upon completion:

(a) Mess specialist 1 retrieves soiled mess gear from

Wards 3, 7, and 4.

(b) Mess specialist 2 retrieves soiled mess gear from wards 1, 5, 6, and 2.

9. Assigned vehicle will pick up soiled mess gear and deliver to scullery.

10. Assigned mess specialist 1 and 2 will assist in scullery clean up of soiled ward gear.

11. Wash, rinse, and air dry ward mess gear.

TAB C-10

SUPPLEMENTAL FEEDINGS

A. **PURPOSE:** To prescribe policy and procedures for obtaining subsistence that is medically required at other than routine meal periods.

B. **DEFINITION:** N/A.

C. **CRITERIA:** Patients whose clinical conditions require supplemental feedings receive same.

D. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED**: N/A.

E. **STEPS**:

1. The Combat Zone environment, austere staffing, limited storage capacity, and absence of single service and/or individual portion containers dictate that supplemental feeding be kept to an absolute minimum and that each be physician prescribed.

2. When a supplemental feeding is required, the ward charge nurse will:

(a) Verify that a chart entry supports the order.

(b) Notify food service by phone of the requirement, providing patient's name, ward number, diet order, and subsistence items required.

(c) Request the time that the order be ready for pick-up (not less than 2 hours after request).

(d) Dispatch an individual to pick up the items at the agree-upon time.

3. Food Service will:

(a) Accommodate supplemental feeding requests.

(b) Obtain required subsistence items and package them suitably.

(c) Release them to the ward representative.

TAB C-11

PROCEDURES FOR RELEASE OF MEDICAL INFORMATION

A. **PURPOSE:** To provide procedures of release of medical information within the hospital.

B. **DEFINITION:** Medical Information - Information contained in the health or dental record of individuals who have undergone medical examination or treatment.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:** N/A.

D. **STEPS**:

Upon presentation of requests for medical information refer to procedures contained in the following references:

1. Manual of the Medical Department, Chapter 23.

2. Freedom of Information Act, BUMEDINST 5720.8.

3. Personal Privacy and Rights of Individuals Regarding Records, SECNAVINST 5211.5.

4. Availability of Navy Records, Policies, SECNAVINST 5720.42.

E. **GENERAL GUIDELINES**:

1. Information contained in health care records of individuals who have undergone medical or dental examination or treatment is personal to the individual and is therefore considered to ba of a private and confidential nature. Information from such health care records, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, should not be made available to anyone except as authorized by the patient or as allowed by the provisions of Manual of the Medical Department and the Privacy Act of 1974 as implemented by SECNAVINST 5211.5 series.

2. Release of information will be coordinated by the Patient Affairs Officer.

3. Personal information of non-medical nature will not be released.

4. Personnel in the patients chain of command may be

provided with information required to conduct command business but will be referred to the Patient Affairs Office.

5. Release of information will conform to local command and superior command policy.

6. All Department Heads shall ensure wide dissemination of this information and compliance with procedures outlined herein.

F. **RESPONSIBILITY:**

1. Director of Administration.

2. Patient Affairs Officer.

3. Charge Nurse or Assistant.

TAB C-12

PROCEDURE FOR PICK-UP AND DELIVERY OF HOSPITAL LAUNDRY

A. **PURPOSE:** It will be logistically impossible to pick up and deliver laundry at each individual ward and CSR. Therefore, this procedure establishes central collection points and the methodology for preparing laundry for turn-in.

B. **DEFINITIONS:** N/A.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED**:

1. Canvas laundry bags.

2. Request for clean linen/laundry.

D. **CRITERIA:** N/A.

E. **STEPS**:

1. Designated Laundry Petty Officer will:

(a) Set up laundry bags, tagging one for bed linen, one for clothing (including patient clothing), and one for contaminated laundry.

(b) Daily at 0800, take the soiled laundry to the nearest Clinical Work Space along with a request for the next day's linen/laundry supply.

(c) Distribute cleaned patient clothing.

2. Linen Control Clerks.

(a) Pick-up and receipt for hospital laundry at each Clinical Work Space.

(b) Collect Requests For Clean Linen/Laundry.

(c) Fill requests submitted the previous day and return cleaned patient clothing.

TAB C-13

PROCEDURE FOR HANDLING AND LAUNDERING CONTAMINATED LINENS

A. **PURPOSE:** The Combat Zone Fleet Hospital will generate a significant amount of contaminated linen within the operating rooms and treatment wards. These items will require special handling and laundering to prevent the spread of infection.

B. **DEFINITION:** Contaminated laundry is defined as those items requiring special disinfection and laundering to preclude the spread of infection.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED**:

1. Chlorine bleach solution.

2. Latex gloves.

D. **CRITERIA:** N/A.

E. **STEPS**:

1. Hospital ward personnel will bag contaminated laundry separate from regular laundry. Gloves are to be worn when handling contaminated laundry.

2. Contaminated laundry will be receipted by the Linen Control Clerks and delivered to the laundry.

3. At the Laundry all contaminated laundry will be segregated from that requiring only routine processing.

4. Based on the next day's requirements and current inventory the contaminated laundry will be assigned a processing priority.

5. The contaminated laundry will be processed as follows:

(a) Presoak the contaminated laundry for 60 minutes in a chlorine solution of 50 ppm.

(b) Wash the linen in hot water using a normal cycle.

6. Once laundered these items will be placed in inventory for re-issue.

F. **RESPONSIBILITY**:

The Head, Environmental Health Department is responsible for routinely monitoring the handling and laundering of contaminated items to preclude the spread of infections.

CAUTION: Extreme care must be taken to avoid contact with the contaminated laundry to prevent the spread of infection to laundry and other hospital personnel.

TAB C-14

PATIENT PROCEDURES FOR HANDLING EXPATRIATED PRISONERS OF WAR

A. **PURPOSE:** To detail patient handling procedures for expatriated prisoners of war within the fleet hospital.

B. **DEFINITION**:

1. Expatriated prisoners of war (EPW) - those patients who require treatment who are prisoners of U.S. or allied combat forces.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED**:

1. Restraints (theater command military police or hospital issue).

2. Others as specified in admission procedures (all forms will be marked with the words “Prisoner of War” or “EPW”).

D. **STEPS**:

1. Upon presentation of EPW to functional area, notify Security Department.

2. Upon admission to Casualty Receiving, Security will be responsible for the following notifications:

(a) Theater command military police (MP) headquarters.

(b) Executive Officer.

(c) Director of Nursing.

(d) Director of Administration.

3. Perform essential life saving care.

4. Inform MP that custody of patient will not be assumed by hospital staff and that MP will retain custody of EPW until relieved by appropriate MP headquarters staff or patient is transferred to EPW holding center (external to hospital).

5. After treatment, have corpsman or litter bearer escort MP and EPW to next functional area charge nurse. Admissions packet, correctly annotated will be delivered by hand to charge nurse.

6. During course of treatment, patient will be guarded by MP and/or restrained until treatment is terminated.

7. Movement to another functional area will be reported to Security.

8. EPW’s will be fed either on the ward or in the general mess. If allowed to eat in the general mess, EPW’s will be accompanied by MP guards.

E. **RESPONSIBILITY**:

CMAA/Security.

TAB D

CLINICAL POLICIES/GUIDELINES INDEX

TAB D-1

INFECTION CONTROL POLICIES

A. Aseptic techniques (with each hand gloved) will be maintained when the patient's condition requires an invasive procedure (i.e., operator procedure, dressing change, ET/Tracheostomy care).

B. Handwashing is essential before and after each patient contact. This should be accomplished with running water and an antimicrobial soap. An alcohol-based cleanser is acceptable in the absence of soap and water.

C. Disease specific isolation procedures will be accomplished as best as possible within the theater of operations. The rationale for utilizing disease-specific precautions rather than an alternative isolation system (category-specific) is conservation of supplies and reduction of expenses. See Table I.

D. Intravascular Access therapy will follow in Table II, remember also to:

1. Change all IV fluid containers every 24 hours.

2. Handle all intravascular devices with aseptic techniques.

3. Change, at the earliest opportunity, all IVs started under dirty conditions. It will be assumed that all patient IVs initiated at echelon 2 will have been performed under aseptic conditions.

E. All open fluid containers will be changed and/or discarded after 24 hours (IV, irrigation, respiratory therapy).

F. All laboratory specimens, blood and body fluids, obtained on patients with potential infectious diseases, are to be considered infectious.

G. Linen and trash must be removed from patient care areas at a minimum of every 12 hours.

H. Reusable equipment will be cleaned and disinfected between each patient. Disposable equipment will not be reused.

I. The isolation standards for infectious diseases will be according to the Center Disease Control (CDC) guidelines, in so far as possible. For further guidance and elaborated

details, consult “Communicable Diseases in Man” (editor, Abram S. Benanson.

Table I

Isolation Policies

A. The following diseases would require as much isolation as possible. However, the preferred method of isolation would include private room, gowns, gloves, and masks:

Disease	Length
1. Chicken Pox	Until lesions are crusted 7-10 days/persons not susceptible, need not wear a mask
2. Diphtheria	Two negative cultures after cessation of antibiotics
3. Echovirus Disease	Seven days after onset.
4. Epiglottitis due to H. Influenza	Twenty-four hours after initiation of effective therapy.
5. Erythema Infectiosum	Seven days after onset.
6. German Measles, Rubiola	Seven days after onset of rash.
7. Hemorrhagic Fevers	Duration of illness.
8. Herpes Zost	Until lesions crusted, people not susceptible, need not wear a mask.
9. Lassa Fever	Duration of illness.
10. Marburg Virus Disease	Duration of illness.
11. Hemophilus Influenza Menigitis	Twenty-four hours after initiationof effective therapy.
12. Neisseria Meningitis	Twenty-four hours after initiation of effective therapy.
13. Meningococcal Pneumonia	Twenty-four hours after initiation of effective

		therapy.
14.	Meningococcemia	Twenty-four hours after initiation of effective therapy.
15.	Multiply Resistant negative. Organism Colonization GI respiratory and skin	Until cultures are Infection or tract,
16.	Mumps	Nine days after onset of swelling.
17.	Pertussis	Seven days after initiation of effective therapy.
18.	Plague, Pneumonia	Three days after initiation of effective therapy.
19.	Pneumonia, Staph Aureus	Twenty-four to forty-eight hours Steptococcus, Group A after initiation of effective therapy.
20.	Rabies	Duration of illness.
21.	Ritton Disease (Staphylococcal scalded = kin syndrome	Duration of illness.
22.	Smallpox	Duration of illness.
23.	Tuberculosis	Two-to-three weeks after chemotherapy.

B. For patients with draining wounds or lesions, with diarrheal diseases/conditions, gloves should be worn by hospital personnel. When splashing or soiling is likely, gowns should be worn.

C. For the following diseases, gloves should be worn when in contact with blood/body fluids:

1. Hepatitis-B, Non-A, Non-B.

2. HIV disease.

3. Rat bite fever (Spirillium minus disease).

4. Relapsing fever.
5. Jakab - Creutzfeldt disease.
6. Leptospirosis.
7. Colorado Tick Fever.
8. Arthropod borne viral fevers (Dengue, Yellow Fever).
9. All forms of clamydial infections.
10. Mucocutaneous (Herpes, Simplex).
11. Malaria.

TABLE II

Summary

Intravascular Access Therapy

Documentation	Duration of Site/Needle	Dressing Change	Tubing Change	of Appearance of Site
Central	Not more than 6 days	72 Hrs	72 Hrs	24 Hrs
Peripheral, Intravenous	72 Hrs	72 Hrs	72 Hrs	24 Hrs
Piggyback Meds	24 Hrs	N/A	24 Hrs	N/A

TAB D-2

BURN WOUND CARE

A. Full thickness burns of greater than 10% will be evacuated to CONUS.

B. Full thickness burns of less than 10% of body surface which do not involve the face or cross a major joint of the extremities will be returned to duty in theater under a 60-day evacuation policy.

C. Partial thickness burns will all RTD in theater under a 60-day evacuation policy.

D. Superficial burns generally do not reach Echelon 3 care except in the large surface area involvement.

E. Generally, all burns will be treated by occlusive dressing and will be changed daily with a reapplication of a topical anti-infective agent. Alternation of Silvadene and Sulfamylon as the topical agents will be used on a 50/50% usage. This procedure will be performed by both physical therapy personnel and nursing personnel.

F. Dressing changes and ward burn care in general will be performed by nursing personnel daily on the burn patients being evacuated from the theater. Care for burned patients which will return to duty in the theater will be provided by the physical therapist.

TAB D-3

SURGICAL GUIDELINES

A. Whenever abdominal, thoracic, or contaminated surgery is being conducted, simultaneous specialty (Orthopedic, Neurosurgical, Ophthalmological, or Vascular) will not be performed.

B. Operating microscopes are available at COMMZ only. Microscopes are nonsupportable in combat zone. They will be placed in a special augmentation package for Echelon 4. (If damage occurs, microscopes will be exchanged; no repair will be done in the theater.)

C. All casting materiel is documented in the Casting “G” module using one of the “G” tasks. Time has been documented for the cast tech for casting in the OR as well as for checks of splints, casts, pins, and fixateurs on the wards. This time is 4 minutes once a day.

D. In all open fractures of extremities a combination of external fixateurs and plastered casting material will be used. For modeling purposes, 75% of the patients will have external fixateurs and 25% will receive plaster material.

E. Irrigating Fluids:

1. DEPMEDS recognizes the requirement for adequate amount of irrigating fluids. However, emphasis should be placed on using the minimal amount necessary because of the tremendous impact on the logistical system.

2. There will be 2 liters of normal saline per operative case.

F. Dressings will ordinarily not be changed prior to day 4 post nitial wound debridement at which time the wound will be examined in the OR for further debridement or delayed primary closure. However, a blood soaked dressing, excessive hemorrhage, and/or sepsis may necessitate wound examination and redressing outside the OR. In the database, all wounds that render the patient non-return to duty within the evacuation policy have a dressing reinforcement in 20% of patients. This category of patients otherwise have dressing reapplied as indicated above in the OR if the stay in theater exceeds 4 days. Further, if the stay exceeded 8 days, another dressing change would be done. For patients returning to duty in the theater, the same policy is in use during initial 4

days and periodic dressing change is accomplished depending on the nature and severity of injury.

G. Blood recovery equipment (or Cell Saver) is available in DEPMEDS at Echelons 3 and 4 and will be used to the maximum extent practical. Anesthesia personnel are responsible to set up and maintain this equipment during operative procedures. Theoretically, this equipment may be used in contaminated and septic cases; however, it is not applied in these cases in the data base. The machine requires a liter of sterile saline with 30,000 units of heparin for primary and an additional liter of saline for each unit of blood recovered. Also, it requires a liter for cleaning. The cleaning of the equipment is modeled under the anesthesia area but will be performed by an operating room technician. The set-up consumables are found in CSG 12 and cleaning consumables are in CSG 22.

TAB D-4

NURSING CARE GUIDELINES

A. The nursing guidelines are designed to provide care at a safe level to save/maintain life, limb, or function.

B. Ward definitions:

1. Intensive Care Unit Patients. Surgical or non-surgical patients whose physiological status is so disrupted that they require immediate and continuous medical nursing care. The care will be provided by specially trained personnel who possess the clinical and managerial skills necessary to deliver safe nursing care to patients with complex nursing and medical problems. Extensive, highly technical care is required because of the patients' inability to maintain vital functions, and communicate needs. Various life support systems, i.e., respirators, monitors, pumps, and/or hypothermia equipment are standard items used in this setting. Examples include patients with massive hemorrhage, neurosurgical, orthopedic, vascular, or burn injuries; post-surgical patients and those with infectious diseases, malaria and fever of unknown origin, and GI conditions, i.e., ulcers and dysentaries.

2. Crash carts which employ all emergency cardiac drugs and a defibrillator monitor will be stationed on all wards to include Emergency Medical Treatment (EMT), Intensive Care Unit (ICU), Intensive Care Ward (ICW), will follow current advanced cardiac life support (ACLS) guidelines and will generally be applied in cardiac arrest cases.

3. Intermediate Care Patients. Surgical or non-surgical patients whose physiological and psychological status is such that they require observation for the presence of real or potential life threatening disease/injury. The acuity of care may range from those requiring constant observation to those patients able to ambulate and assume beginning responsibility for their care. This patient may require monitoring devices, ventilator support, IV therapy, frequent suctioning, dressing changes/reinforcements and ambulation.

4. Minimal Care Patient. Surgical or non-surgical patients who are ambulatory and partially self-sufficient who require limited therapeutic and diagnostic services and are in the final stages of recovery. Focus of nursing management is on maintenance of a therapeutic environment which enhances recovery. Complexity of care includes administering of oral

medications and treatments which cannot be done by patients and providing instruction in self-care and post-hospitalization health maintenance.

5. Convalescent Patient. Surgical or non-surgical patients who are ambulatory and self-sufficient. Complexity of care requires limited therapeutic and administration of oral medications performed by the patient. They are in the final stages of recovery and could be returned to limited duty. Emphasis in this area is on physical reconditioning.

C. Intravenous Therapy is addressed in the Infection Control Policies.

D. Oxygen will be administered to all patient conditions (PCs) that exhibit signs and symptoms of moderate to severe respiratory distress, hypoxia, penetrating chest wounds, and moderate to severe cardiovascular compromise, i.e., (shock) (Classes III and IV hemorrhages). The rate of oxygen administration is three liters per minute irrespective of the means delivered. Head injuries are to receive hyperventilation with 40% oxygen to decrease the risk and extent of cerebral edema.

E. Heparin lock will be initiated in all patients that require IV medications after the intake of a normal amount of food and fluids by mouth or enteral feeding.

F. Enteral feeding is used in those patient conditions that have normal gastrointestinal functions but are otherwise not able to eat because of sensorium changes.

G. Hyperalimentation is utilized in the clinical data base on those patients that are not taking gastrointestinal alimentation by some means by the 4-5 day post injury or illness. In the data base at present is the use of central hyperal only.

H. Nasogastric tubes will be irrigated once per 12-hour shift.

I. Oral hygiene will be provided daily for each ICU patient and ICW patient who is unconscious or incapacitated.

J. Partial bath (face, hands, perineum and skin care) will be provided daily on all ICU and ICW patients who are unconscious or incapacitated.

K. Linen will be changed daily on all ICU and ICW patients who have draining wounds. On MCW, linen will be changed

weekly. Disposable bed protectors (chucks) will be used on patients who have draining wounds.

L. Vital signs in Minimal Care Wards (MCW) will be taken and recorded once weekly.

M. On minimal care patients, dressing changes will be provided by nursing care unless these patients will go to PT.

N. Documentation for ICU patients will be every 12 hours. ICW will be every day and MCW every week or as indicated by patient condition.

O. Nursing assessment will be accomplished on admission to each nursing unit, every shift in ICU or as indicated by patient condition; ICW every shift, and MCW weekly.

P. Enlisted personnel will perform in accordance with unit SOPs under the supervision of professional nurses or physicians.

Q. Hyperal tubing will be changed every 48-72 hours unless fat emulsions are used and then the tubing is discarded after each use.

R. The ICU staff will be proficient in all aspects of respiratory therapy, to include ventilator set up, Intermittent Positive Pressure Breathing (IPPB), pulmonary toilet, etc.

S. Intake and Output measurements will be done on all ICU patients, those intermediate care patients who require this and all hyperale patients.

T. IVs will be changed every 3d day. At this time there will also be an IV dressing change.

U. Cardiac monitoring will be conducted in all patients conditions exhibiting Class III and IV hemorrhages, moderate to severe chest trauma or disease and other conditions with moderate to severe respiratory distress in a patient description and those patients requiring tracheostomies. A patient will be maintained on a monitor for varying lengths of time depending on the severity of the disease or the injury.

V. See hospital infection control section for hospital established program.

TAB D-5

NUTRITION CARE GUIDELINES

A. All dietary tasks are keyed to the ward on which the patient is admitted by means of the double alpha prefix: YI - Intensive Care Unit (ICU) Patients, YJ - Intermediate Care (ICW) Patients, YK - Minimal Care (MCW) Patients, YR - Convalescent Patients.

B. It is assumed that 100% of ICU and ICW patients receiving diets will require ward feeding. In general, 90% of MCW patients are assumed to be ambulatory and will be fed in the dining facility (task 019). An assumed 10% of MCW patients will require ward service due to occasional minor complications. Exceptions to this 90%, 10% rule are reflected by greater percentages in tasks of diet preparation and delivery. 100% of convalescent patients will eat regular diets in the dining facility.

C. No food preparation tasks were added if a patient was Not By Mouth (NPO), although nutrition assessment tasks may have been included. If the food preparation tasks do not add up to 100% on a given ward, it can be assumed that some patients were NPO.

D. When patients were required to be NPO for surgery and operative time was less than three hours, the patients were made NPO for one meal only by using an occurrence of 2 times on day one.

E. Varying dietary treatments/progressions were defined one of two ways. First, certain tasks would be designated to occur on day one and not on repetitive days, while other tasks occurred on repetitive days and not on day one. The second method, used when more than one day and/or several diets were required, split the length of stay into percentages of time on a given diet. Either method, but particularly the latter, may be invalidated each time length of stay scenarios are altered.

F. A basic assumption was made that the powdered formula products would be available and that preparation of these products would require a blender (tasks Y004, Y015, and Y016). The product currently available is a canned product which may not require nutrition care personnel to be involved in the preparation and delivery. However, the task of nutritional assessment (Y001) is required regardless of who prepares the tube feeding.

G. Assuming the availability of a soft plastic tube, nursing tasks for removal of the hard NG tube used for suction, and insertion of the soft tube were included for those patients expected to remain tube fed for extended periods of time.

H. Tasks for forced fluids and nourishments, when appropriate, were included on the MCW for 100% of the patients and were expected to be delivered with the 10% receiving meals on the ward.

TAB E

STANDARDS AND JOB DESCRIPTIONS INDEX

TAB E-1

ACUTE CARE WARD EVALUATIVE STANDARDS

1. Standard Operating Procedure for Acute Care ward is available on ward.

2. Emergency Cardio Resuscitation Kit and Drug Box are checked daily as validated by Emergency Kit Check Off Sheet.

3. Cardio resuscitation and defibrillation procedures are performed IAW SOP.

4. Waste materials are disposed of safely in proper receptacles in assigned areas of hospital every watch.

5. Medical supplies are restocked on a QOD basis and as needed.

6. Safety standards are observed in using equipment, transporting/moving patients, and evacuating patients in case of fire.

7. All staff are able to locate Evacuation Flow Chart and Fire Bill on ward.

8. The Pharmacy Protocol for controlled drugs is observed by charge nurse. All controlled drugs are inventoried at start of every watch with signature of on-coming nurse and off-going nurse on SF 67610.1.

9. Drug requisition form will be sent to Pharmacy by 1000 daily.

10. Procedure for meals will be implemented so correct diets are given in a timely manner.

TAB E-2

SAFETY PRECAUTIONS

A. **PURPOSE**: To maintain a safe, clean environment.

B. **DEFINITION**: N/A.

C. EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:

1. Needle destruction box.

2. Sink.

3. Bedpan washer.

4. Cleaning materials.

D. **CRITERIA**:

1. All broken equipment will be removed from ward for repairs as defect is discovered.

2. Staff will be instructed on proper techniques in lifting and handling patients and equipment.

3. Hospital procedures for disposal of wastes will be followed.

E. **STEPS**:

1. General precautions.

(a) Enforce NO SMOKING regulations.

(b) Wipe up spills immediately.

(c) Display signs to denote:

(1) Hazardous materials in use.

(2) Wet floors.

(3) Oxygen in use.

(4) Isolated areas.

(d) Keep passageways clear of furniture, equipment, and

debris.

2. Needle precautions.

(a) Dispose of used needles in needle destruction boxes.

(b) Report needle stick to charge nurse immediately.

(c) Get medical attention IAW NAVMED P-5010.

(d) Store needles and syringes in an appropriate section of the ward medical locker.

3. Waste precautions.

(a) Handle hazardous wastes, i.e., excretions, sera, blood, etc., IAW guidelines established by Environmental Health Department.

(b) Clean bedpans in Clinical Workspace, only.

(c) Prepare specimens in Clinical Workspace, only.

4. Personal safety.

(a) Use good body mechanics when transporting litters, lifting or positioning patients IAW TAB F-1.

(b) Avoid x-ray exposure.

(1) If possible, leave area when x-ray is being taken.

(2) Wear a lead apron if you must remain with patient.

(c) Wash hands between each patient whenever possible.

(d) Use caution when breaking a glass ampule to avoid cutting fingers. Use a file and cover finger tips with a piece of gauze for protection.

5. Patient safety.

(a) Identify patients at high risk for falls. Those who:

(1) Are receiving narcotics or sedatives.

(2) Are disoriented or debilitated.

(3) Require ambulation devices such as crutches, canes, etc.

(b) Prevent patient falls and mechanical ambulation injuries.

(1) Teach patients to use ambulatory devices correctly.

(2) Assist weak patients with ambulation.

(3) Ensure patients wear proper footwear when ambulating.

(c) Beds and examining tables.

(1) Caution patients to turn slowly in bed due to narrowness and height of table/bed.

(2) Attend patients frequently while they are are on examination table.

(3) Restrain patient as necessary using safety straps.

(4) Strap unattended patients to bed using abdominal body strap.

(d) Chairs/wheelchairs.

(1) Attend patient in chair if condition warrants.

(2) Lock wheels on wheelchair in transferring patient from chair to bed.

(3) Caution patient never to step on foot rest of wheelchair.

(e) Leather cuff restraints.

(1) Use leather cuff restraints to protect patients from self-injury and infliction of injury on others.

(2) Explain to patient that restraints are

protective not punitive measures.

(3) Allow moderate movement of extremities.

(4) Check circulation on restrained extremities every 2 hours.

(5) Change patient’s position every 2 hours to prevent discomfort, muscle and nerve damage, and skin breakdown.

(6) Remove restraints one at a time to do range of motion exercises every 4 hours.

(7) Provide skin care to extremities every four hours.

(f) Heat applications.

(1) Ensure that all equipment is in proper working order.

(2) Observe patient closely to prevent burns.

(3) Apply heat lamp at a safe distance from patient for 15 minutes per treatment.

6. Environmental safety.

(a) Avoid electrical shock.

(1) Use extension cords in accordance to command policy.

(2) Use only grounded electrical equipment unless cleared through Medical Repair Division.

(3) Prevent shock and fire by checking electrical cords for defects and fraying.

(b) Oxygen safety regulations.

(4) Display “Oxygen in Use” sign.

(5) Chain or support all oxygen cylinders in holders.

(6) Do not use oil, grease, or flammable liquid on equipment.

(7) Prevent static electricity by not using wool materials.

(8) Remove antiseptic tinctures and alcohol from immediate oxygen environment.

(9) Keep oxygen storage free of combustible material.

(10) Monitor cylinder pressure readings. Change cylinder if p.s.i. is 100 or less.

(11) Keep wrench with cylinder.

F. **RESPONSIBILITY**:

1. Charge Nurse.

2. Senior Corpsman.

TAB E-3

EMERGENCY CARDIO RESUSCITATION KIT

A. **PURPOSE:** To provide appropriate supplies/equipment needed during emergency situations.

B. **DEFINITION:** N/A.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED**:

1. Emergency Cardio Resuscitation Kit (Sparks Kit).

2. Emergency Kit Inventory List.

3. Emergency Kit Checkoff Sheet.

D. **CRITERIA**:

1. Emergency Cardio Resuscitation Kit is readily accessible.

2. Kit is completely stocked and inventoried when seal is intact.

3. Oxygen cylinders and seals on Emergency Cardio Resuscitation Kit will be checked every watch.

E. **STEPS**:

1. Emergency Cardio Resuscitation Kit will be located on the Acute Care Ward at all times. It will be used only for cardio resuscitative emergencies.

2. Senior Corpsman on each watch will check to ensure seals have not been broken, and oxygen pressure in cylinders is sufficient, that is psi is not less than 100.

3. Inventory emergency Cardio Resuscitation Kit every three months or when seals have been broken.

4. Check daily the Emergency Kit Inventory List posted on the outside of kit for drug expiration dates.

5. Initial Emergency Kit Checkoff Sheet daily (TAB J-1).

6. Senior Corpsman will be responsible for re-supplying kit during normal working hours. The Watch LPO assumes this

responsibility at other times.

F. **RESPONSIBILITY**:

Senior Corpsman or his representative.

TAB E-4

ORIENTATION TO ACUTE CARE WARDS

A. **PURPOSE:** To ensure that ward personnel are familiar with the physical layout of the Fleet Hospital, ward assignments, equipment, and routine procedures when they report for duty.

B. **DEFINITION:** N/A.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED**:

1. Drawings of the spaces.

2. Equipment and material lists.

3. Forms used on wards.

D. **CRITERIA**:

1. Due to the short time frame between gear-up and operational mode, staff must be able to utilize equipment upon arrival.

2. Training with equipment must be completed prior to operation of hospital.

E. **STEPS**:

1. Review with staff equipment, supplies, and standard forms used on wards.

2. Review the Acute Care Ward SOP with personnel.

3. Conduct supplemental classes as needed.

F. **RESPONSIBILITY**:

1. Charge Nurse.

2. Senior Corpsman.

TAB E-5

NURSING WARD CLEANING SCHEDULE

A. **PURPOSE**: To keep the environment as clean as possible.

B. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED**:

1. 4 scrub basins/buckets.
2. Gloves.
3. Wet vacuum.
4. Scrub brushes.
5. Sponge mop.
6. Wipes.
7. Detergent, GP.
8. Germicidal solution.
9. Laundry bag.
10. Plastic, water soluble laundry bag.
11. Plastic trash bag.
12. Covered container for medical/dental wastes.

C. **CRITERIA**:

1. Soiled linens, trash, and medical wastes are removed at end of watch and as needed.
2. Decks will be wet-vacuumed daily.
3. Counter tops will be cleaned daily.
4. Temper Tent equipment, shelving, litters are cleaned weekly.
5. Refrigerator and ice machine are cleaned weekly.

D. **STEPS**:

1. Watch cleaning schedule.

(a) When patient is discharged, field day the area and restock supplies to be ready for next admission.

(b) Check psi level on each oxygen cylinder. Notify medical supply to replace oxygen cylinder when near 100 psi.

(c) Remove cloth laundry bags when full and place in utility module for laundry to pick up about 1000 daily.

(d) Empty drainage bottles into a covered medical waste container.

(e) Empty trash into plastic bags and dispose of at designated trash area.

(f) Take used sterile instruments to CSR Support Module for reprocessing.

2. Daily cleaning schedule.

(a) Wash decks with wet-vacuum on night watch.

(b) Wipe down counter tops on night watch.

(c) Restock supplies on night watch.

3. Weekly cleaning schedule.

(a) Wipe down litter racks, storage cabinets, shelving, and desk tops.

(b) Clean the refrigerator and ice machine.

E. **RESPONSIBILITY**:

Senior Corpsman or LPO will assign cleaning details to watch.

TAB E-6.1

WARD MEDICAL OFFICER JOB DESCRIPTION

The Ward Medical Officer is responsible for an Acute Care Ward. He reports to the Head, Medical Department.

THE WARD MEDICAL OFFICER WILL:

1. Set policies and procedures for the medical care given on the Acute Care Ward.

2. Orient medical officers to Acute Care Ward.

3. Receive report from medical officer on previous watch and make brief patient rounds prior to assuming the watch.

4. Perform an admission history and physical exam on each patient admitted directly to the ward. Record information on SF 539.

5. Completely evaluate each patient admitted or transferred to ward.

6. Write doctor's orders on SF 508. Co-sign all verbal orders within 24 hours.

7. Write daily progress notes on patient's chart.

8. Make rounds with nursing staff at 0830 to examine and re-evaluate all patients.

9. Review all laboratory data, x-rays, and other diagnostic tests.

10. Review all medications and renew antibiotics, narcotics and other controlled drugs IAW Pharmacy policies.

11. Sign S.I. and V.S.I. chits. Pronounce patients at time of death and write death note.

12. Write transfer or discharge notes on all patients leaving the ward.

13. Contribute to personnel performance evaluations.

14. Participate in an orientation and training program.

15. On night watch, cover two acute care wards.

QUALIFICATIONS:

1. Designator 2100/2105 Physician.

2. Advance Cardiac Life Support (ACLS) certification recommended.

3. Graduate Intermediate LMET Course.

4. Compteted Fleet Hospital Operation and Maintenance Training.

TAB E-6.2

CHARGE NURSE JOB DESCRIPTION

The Charge Nurse is responsible for the management of nursing personnel and nursing care on Acute Care Wards and reports to Patient Care Coordinator and ward Medical Officer.

THE CHARGE NURSE WILL:

1. Assess, plan, implement, and evaluate patient care IAW standards for nursing practice.

2. Assign duties to professional and ancillary staff members.

3. Supervise and evaluate individual work performance in terms of patient care, staff relations, and efficiency of service. Prepare formal, written evaluations when required.

4. Coordinate patient care with other departments and services within the hospital. Promote good interpersonal and interdepartmental relationships.

5. Promote staff development through inservice classes and cross training. Counsel personnel with deficits, identifying capabilities and training needs.

6. Ensure that established policies, procedures, and routines are current and available in the nursing ward standard operating procedure manual.

7. Participate in patient care performing the following tasks:

    a. Medications.

    b. Parenteral drug/blood product administration (Level III Certified).

    c. Nasogastic tube insertion and irrigation.

    d. Urinary catheterization.

    e. Oxygen administration.

    f. Other emergency treatment measures.

8. Report all pertinent information to the Patient Care

Coordinator and ward Medical Officer.

9. Evaluate patients by observing, recognizing, recording, and reporting changes in patients' conditions, subjective and objective symptoms, reaction to medications, and response to therapy.

10. Prepare patients for surgery. Obtain written consent for surgery and anesthesia on SF 522. Verify items on surgical check list were completed and are recorded.

11. Review lab, x-ray, and other diagnostic test results on patients.

12. Ensure that proper documentation is done on patients. Doctor's orders are signed by Medical Officer within 24 hours or before patient is transferred.

13. Maintain a clean, safe, and orderly environment. Ensure that field beds are cleaned after patient discharge.

14. Prepare watch schedules for personnel as directed, using staff policy for the hospital.

15. Comply with established inventory procedures to account for narcotics, controlled drugs, and other dangerous substances.

QUALIFICATIONS:

1. Designator 2900/2905, NOBC 0940, Medical Surgical Nurse Subspecialty Code 1910.

2. Advanced Cardiac Life Support (ACLS) certification.

3. Level III Certification for administering parenteral fluids and blood products IAW NAVMEDCOMINST 6550.3.

4. Graduate Intermediate LMET Course.

5. Completed Fleet Hospital Operation and Maintenance Training.

TAB E-6.3

STAFF NURSE JOB DESCRIPTION

The Staff Nurse performs nursing duties as a team leader on an Acute Care Ward. The Staff Nurse is supervised by the charge nurse on the ward. The staff nurse is responsible for supervising corpsman on team.

THE STAFF NURSE WILL:

1. Coordinate the nursing process; assess, plan, implement, and evaluate nursing care IAW nursing standards of practice.

2. Provide nursing care to patients as a member of a treatment team. Specifically the staff nurse will:

    a. Obtain vital signs.

    b. Obtain preliminary history if possible.

    c. Initiate peripheral IVs as ordered.

    d. Catheterize/assist with catheterization of patient.

    e. Insert a nasogastric tube if needed.

    f. Monitor physiological status; Glasgow coma test, pupillary checks, circulation checks, urinary output.

    g. Administer medications and blood products IAW, NAVMEDCOMINST, 6550.3

    h. Reassure anxious patient.

3. Assist and direct new nurses and corpsmen in performance of medical-surgical nursing care.

    a. Conduct classes on new procedures.

    b. Supervise orientation of corpsmen to nursing procedures.

4. Initiate cardio-pulmonary resuscitation and other life support measures as needed.

5. Coordinate lab, x-ray and other diagnostic tests being performed on patients.

6. Give report to nurse in another hospital area to which patient is being transferred.

7. Maintain anecdotal notes on staff.

8. Locate and operate all emergency equipment on ward.

9. Assist with replenishment of supplies and repairs of equipment.

QUALIFICATIONS:

1. Designator 2900/2905, NOCB 0944.

2. Previous experience in medical-surgical nursing is required.

3. Advanced Cardiac Life Support (ACLS) certification is recommended.

4. Level III certification for administering parenteral fluids and blood products IAW NAVMEDCOMINST 6550.3.

5. Completion of medication orientation course.

6. LMET Course recommended.

7. Fleet Hospital Operation and Maintenance Training recommended.

TAB E-6.4

SENIOR CORPSMAN JOB DESCRIPTION

The Senior Corpsman is directly responsible to the charge nurse of an Acute Care Ward for the overall performance, military conduct, and appearance of corpsmen assigned to the ward.

THE SENIOR CORPSMAN WILL:

1. Assist the charge nurse with coordinating daily staffing, teaching, counseling, and general supervision of corps staff.

2. Orient new corpsmen to Acute Care Ward.

3. Ensure the chain of command is followed, that all staff know chain of command, and proper routing for special requests.

4. Conduct monthly staff meetings to convey information, discuss problems, and contribute to the problem solving process.

5. Monitor and maintain adequate administrative and patient care supplies. Order supplies from:

    a. Support CSR - sterile instruments.

    b. Medical Supply - medical supplies.

    c. Supply - forms and administrative items.

    d. Laundry - linens.

6. Monitor the safety and function of all equipment. Submit work request to Medical Repair and track progress on work requests.

7. Ensure staff is familiar with the procedures for fire, cardiac arrest codes, securing weapons, and general safety procedures.

8. Ensure proper disposition of contaminated instruments, equipment, and materials.

9. Make rounds to ensure staff meets patient needs and work is being completed efficiently.

10. Assist corpsmen with patient care and procedures as needed. Serves as resource to corpsmen on ward.

11. Responsible for Acute Care Ward appearance. Make cleaning assignments and ensure area is clean before watch is secured. Prepare area for inspection and accompany the Inspecting Officer.

12. Counsel corpsmen as needed about work performance including career development.

13. Maintain good interpersonal relations with other hospital departments and staff members.

14. Report to and obtain assistance from Charge Nurse as needed.

15. Ensure that all daily logs and records are completed correctly.

16. Check emergency Cardio Resuscitation Kits and Oxygen Cylinders daily.

17. Prepare and submit monthly watch bills.

18. Pass word to on coming watch.

19. Perform other duties as assigned by Charge Nurse.

QUALIFICATIONS:

1. Petty Officer (E-4 or above preferred).

2. Six months experience on Medical-Surgical Ward is required.

3. Basic Cardiac Life Support (BCLS) certification.

4. Level II certification IAW NAVMEDCOMINST 6550.3 to initiate and monitor parenteral IV Fluids.

5. Medication certification.

6. Possess knowledge of hospital policies and procedures as well as military regulations, procedures, and protocol.

7. LMET - LPO Course graduate.

8. 25% of E-4s and below will have completed Field Medicine school.

9. Fleet Hospital Operations and Maintenance Training completed.

TAB E-6.5

STAFF CORPSMAN JOB DESCRIPTION

The Staff Corpsman, responsible to the Senior Corpsman on an Acute Care Ward is assigned general duty assignments.

THE STAFF CORPSMAN WILL:

1. Give nursing care IAW the standards for nursing practice.

    a. Obtain vital signs.

    b. Monitor intake and output.

    c. Change dressings as ordered.

    d. Assist patient with activities of daily living as needed.

    f. Administer medications by all routes except IV push.

    g. Reassure and support patient.

    h. Administer oxygen therapy.

2. Perform CPR if code is called and quickly locate and operate emergency equipment as required.

3. Assist in replenishment of supplies.

4. Field day bed space when patient is discharged.

5. Assist in orienting new staff corpsmen to area.

6. Maintain a professional relationship at all times with staff and patients, and recognize and follow the chain of command.

7. Transport patients to other hospital areas.

8. Run lab specimens to laboratory module.

9. When work is completed, report to senior corpsman for further assignment.

10. Pass word to oncoming watch.

QUALIFICATIONS:

1. Completion of “A” school (Hospital Corps School).

2. Previous ward experience is highly recommended.

3. Basic Cardiac Life Support (BCLS) certification.

4. Level II certification IAW NAVMEDCOMINST 6550.3 to initiate and monitor parenteral IV fluids.

5. Completion of medication orientation course.

TAB F

REFERENCES INDEX

Number	Title
F-1	NAVMED P-5066-A, Navy Nursing Procedures Manual.
F-2	Basic Cardiac Life Support (BCLS) Interim Guidelines by the American Heart Association.
F-3	Advanced Cardiac Life Support (ACLS) Interim Guidelines by the American Heart Association.
F-4	NAVMED P-5010 Navy Preventive Medicine Manual.
F-5	NAVSUP Pub 436 Standard “B” Medical Rations for the Armed Forces.

TAB G

FORMS INDEX

G-21	NAVMED 6320/5	Serious/Very Serious Condition or Death of Patient on Ward
G-22	NAVMED 6710/4	Narcotic and Controlled Drug Inventory - 24 Hour
G-23	NAVMED 6010/14	Incident Reporting Data Sheet
G-24	FHCZ 2606	Evacuation Flow Chart
G-25	DA 3910	Death Tag
G-26	DD 2064	Certificate of Death (Overseas)
G-27	DD 599	Patients Effects Storage Tag
G-28	NAVMED 6010/8	Patients Valuables Envelope

TAB G-1

EMERGENCY KIT DAILY CHECKLIST

FHCZ (7-86)

MONTH/YEAR: _____ WARD: _____

DATE	TIME	PERSON CHECKING SIGNATURE	02/PSI	DISCREPANCIES	FOLLOW-UP	CHARGE NURSE SIGNATURE
1						
2						
3						
4						
5						
6						
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TAB G-3

SURGICAL CHECK LIST

FHCZ (7/86)

ADDRESSOGRAPH HERE

WARD

O. R.

I.D. BAND ON

Surgical/Anesthesia Permit

Signed

History & Physical

Allergies

NPO after midnight

Blood Work Done

Urinalysis

Lab work ordered butresults not yet known

Chest X-Ray

BP Taken

TPR Taken

Operative Area Prepped

O.R. Cap - Gown

Voided or Catheter Inserted

Contact lenses and
glasses removed

Dentures removed

Name Plate on chart

Type and Crossmatch

Predications of

Time Given

Date

Ward Nurse

Surgery Nurse